UNCOMPENSATED HOSPITAL CARE: IN MEMORIAM: WILLIAM TRUMBALL

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

MARCH 12, 1987

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UNCOMPENSATED HOSPITAL CARE: IN MEMORIAM: WILLIAM TRUMBALL

THURSDAY, MARCH 12, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m. in room B-318, Rayburn House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, FEBRUARY 20, 1987

PRESS RELEASE #4
SUBCOMMITEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.),
CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON
HOSPITAL INDIGENT CARE
TO BE HELD ON THURSDAY, MARCH 12, 1987

The Honorable Fortney H. (Pete) Stark (D.,Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, today announced a hearing on hospital indigent care. The hearing will be held on Thursday, March 12, 1987, beginning at 9:30 a.m., in room B-318 Rayburn House Office Building.

Chairman Stark stated, "From their beginning, the Nation's hospitals have maintained a strong tradition of charity. Hospitals have responded to those who needed care, not to those could pay. In today's health care environment many hospitals are finding they must reduce charity care to remain solvent. Some of these public and voluntary hospitals are the only source of medical care for the poor. The survival of these hospitals is crucial for assuring needed care."

Stark said, "The Subcommittee will consider the issue of Federal support for hospitals in financial difficulty because of their continuing committment to patients who cannot pay."

BACKGROUND

The American Hospital Association's data from their 1985 survey show that uncompensated care cost hospitals $9.5 billion. This is more than twice the 1980 costs of $4.6 billion.

Not all hospitals share equally in providing uncompensated care. Public hospitals provide 40 percent of uncompensated care, but account for only 22 percent of all hospital care. Large metropolitan public hospitals account for 20.5 percent of the total uncompensated care, but provide only 5.5 percent of all care. Hospitals with large neonatal, obstetrics, burn, and outpatient care services have the highest levels of uncompensated care.

The large increases in hospital uncompensated care since 1980 have stressed many hospitals. Studies show that the hospitals with the most generous committment to the poor are those most financially troubled. These same hospitals generally receive substantial State and local subsidies, but continue to suffer because of low volu s of insured patients.

Witnesses at the hearing will include representatives from public and voluntary hospitals, hospital analysts, and representatives from State and local governments.

- MORE -

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Thursday, April 2, 1987, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE ENCLOSED FORMATTING REQUIREMENTS.

*****

Chairman STARK. The Health Subcommittee of the Ways and Means Committee will begin its hearing on uncompensated health care.

Before I call the first witnesses, I'd like to take the unusual step of dedicating this hearing to the memory of a constituent of mine, Mr. William Trumball of Castro Valley, CA. By dedicating this hearing to Mr. Trumball, I hope to make it very clear what we're talking about today—life and death.

Bill Trumball died this last January at the age of 27. He died because he did not have health insurance. When he entered the hospital in great pain, he felt so hounded for money or a deposit, that he left rather than subject his family to huge hospital bills.

I hope the memory of his life and of similar incidents in each of our congressional districts will finally spur us to move on legislation that will make it easier for individuals to buy healtn insurance and that will take financial pressures off the hospitals. Hospitals and doctors should not have to ask questions about a person's ability to pay before performing life saving tests.

Today the subcommittee welcomes a number of distinguished witnesses as we focus on uncompensated hospital care.

Uncompensated care is reported by the hospitals as the sum of bad debts and charity care. In 1985 the American Hospital Association reported almost $7½ billion in uncompensated hospital costs.

This is a problem for all hospitals, but especially the public and voluntary, not-for-profit hospitals that provide large amounts of uncompensated care.

I am concerned about access problems for the people they serve if these hospitals are forced to close or curtail their services.

There are a number of questions about uncompensated care we will address today. First, why has uncompensated care become such a problem for the hospital industry.?

Second, are some hospitals severely stressed because of uncompensated care alone? Many of these hospitals provide services that traditionally lose money and are, therefore, less attractive to other community providers.

Third, are the financially troubled hospital inefficient and poorly managed, or are these hospitals as efficient and well-managed as other hospitals? In other words, is it just a question of the people who seek aid through their emergency rooms or front doors? Patient mix and the type of community served by a hospital seem to be among the best predictors of financial distress. We hope to find out today.

Fourth, what is the Federal role in solving these problems of hospital uncompensated care? I'm convinced this is a national problem that requires a national response.

The States differ in their ability to contend with the burdens of uncompensated care, and in many instances are stretched to the limit.

A bill that Senator Kennedy and I introduced last year, health care access bill, would have required States to establish a mechanism to fund hospital uncompensated care. This year I hope we will consider a national program that addresses the costs of charity care and uncompensated care.

[Chairman Stark's opening statement follows:]

OPENING STATEMENT

THE HONORABLE FORTNEY H. (PETE) STARK
CHAIRMAN, SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
HEARING ON
HOSPITAL UNCOMPENSATED CARE
MARCH 12, 1987

I would like to take the unusual step of dedicating this hearing to the memory of William Trumball of Castro Valley, California.

I dedicate this to Bill Trumball in order to make real what we are talking about today: we are talking about life and death. We are talking about young men like Bill Trumball who died this January at the age of 27.

He died because he did not have health insurance and because when he entered a hospital in great pain, he felt so hounded for money that he left and died rather than subject his family to huge hospital bills. It will be a matter for the courts to decide why certain tests that would have detected a blood clot and saved his life were not run on Bill Trumball. But his family reports that he left for reasons of financial pressure.

I hope that the memory of his life, and of similar incidents in each of our Congressional districts, will finally spur this Congress to enact legislation to make it easier for individuals to buy insurance and to take the pressure off hospitals to ask questions about a person's ability to pay before they run life-saving tests.

Today the Subcommittee welcomes a number of distinguished witnesses as we focus on uncompensated hospital care.

Uncompensated care is reported by hospitals as the sum of bad debt and charity care. In 1985, the American Hospital Association reported $7.4 billion in uncompensated hospital costs.

This is a problem for many hospitals, especially the public and voluntary, not-for-profit hospitals that provide large amounts of uncompensated care. I am concerned because the financial difficulties of these hospitals may lead to serious access problems for the people they serve if they are forced to close or curtail services.

Many hospitals throughout the nation are providing uncompensated care.

First, there are our public hospitals; large, urban facilities serving large poor populations. They provide more than 40% of uncompensated care, but account for only 22% of the nation's hospital beds. In our 100 largest metropolitan areas, public hospitals account for 21% of the uncompensated care, although they have only 5.5% of the beds. Many of these public hospitals are also teaching hospitals.

Second, the voluntary, not-for-profit hospitals also provide large volumes of uncompensated care. These hospitals are the principal access to care for the poor in about half of our major metropolitan areas.

Third, are our rural hospitals. Of the 2700 rural hospitals in the nation as many as 600 may close by 1990. Three hundred and forty five are the sole community provider of hospital care. In 1984, 30% of the rural hospitals reported operating deficits greater than 6%, compared to 14% of urban hospitals.

There are a number of questions about what to do about the problems of hospital uncompensated care.

First, why has uncompensated care become such a problem for the hospital industry? Large cutbacks in Medicaid under the Reagan Administration have forced many States to reduce the number of poor covered, thus further exacerbating the problem of uncompensated care.

The new strategies adopted by business and government to moderate health care costs are eroding the traditional methods of financing uncompensated care. Cost shifting has been our traditional, Robin Hood approach to financing hospital care for the poor. This implicit means of supporting uncompensated care has not been replaced by an explicit means of support.

Second, are some hospitals severely stressed financially because of uncompensated care alone? Many of these hospitals provide services that traditionally lose money and are, therefore, less attractive to other community providers. For example, obstetric services are a source of large bad debts, the costs in neonatal intensive care units far exceed reimbursement rates, and outpatient departments are plagued by both bad debts and high costs.

The AIDS epidemic is yet another source of financial stress for a number of our safety net hospitals.

Third, are these financially troubled hospitals the inefficient and poorly managed losers in a changing hospital industry? In general, these hospitals are as efficient and as well managed at their private counterparts. Patient mix and the type of community served by the hospital are better predictors of financial distress.

And fourth, what is the Federal role in solving the problems of these ailing hospitals? I am convinced this is a national problem that requires a national response. The States differ in their ability to contend with the growing burdens of uncompensated care and in many instances are stretched to the limit of support they can commit.

Last year's Stark-Kennedy "Health Care Access" bill would have required states to establish a mechanism to fund hospital uncompensated care. <u>This year we should consider a national program that addresses hospital charity care costs</u>.

Chairman STARK. Our first panel this morning consists of Dr. James Mongan, the executive director of the Truman Medical Center in Kansas City, MO.

Mr. Joel Allison, the chairman of the Texas Association of Public and Nonprofit Hospitals and the executive director of the Amarillo Hospital District in Amarillo, TX.

Unfortunately, Mr. Pickle will not be able to join us this morning for our hearing. He's chairing another subcommittee. Mr. Allison, Mr. Pickle asked me to welcome you to the subcommittee. He appreciates your willingness to present the fine work of the Texas Association of Public and Nonprofit Hospitals. He wanted me to recognize your work on behalf of the poor and needy of Texas, and commend you as others around the Nation have done.

Edward Connors, president of the Mercy Health Services of Farmington Hills, MI, and Ann Brown, the Administrator of Jefferson County Hospital, Fayette, MS.

I'd ask the witness please to come forward to the witness table.

All of your prepared statements that we receive will be inserted in the record in their entirety. I would encourage all the witnesses to summarize or expand on their statements in any way they're comfortable, and in general we would attempt to ask you to hold your presentation to approximately five minutes. The members of the committee will have questions and that will extend the inquiry and give you a chance to respond to areas of which you piqued our interest.

Do any of the other members have any comments before we begin?

Dr. Mongan, you will lead off.

STATEMENT OF JAMES J. MONGAN, M.D., EXECUTIVE DIRECTOR, TRUMAN MEDICAL CENTER, KANSAS CITY, MO

Dr. MONGAN. Mr. Chairman, I'm Dr. Jim Mongan. I'm executive director of the Truman Medical Center, the Public Hospital System for Kansas City, MO. I deeply appreciate your committee's recognition of the importance of the indigent care issue, and its impact on hospitals.

I believe I can best use my brief few minutes before this committee by putting flesh and blood on the abstract policy debates surrounding indigent care. In other words, by telling you what's going on in the very real world of Kansas City.

Mr. Chairman, there's a rapidly growing problem with indigent care. If the fact that we've gone from 28 to 35 million people without health insurance does not get your attention, let me give you some numbers from my world. In the past 5 years the number of admissions at Truman Medical Center have increased by 28 percent. This is in stark contrast to a 24 percent decline in admissions at other area hospitals. Our outpatient visits are up 41 percent over this period. We're a fine hospital, but that's not what's causing this flood of patients. It's an increased number of people without adequate coverage, and it's put a staggering burden on our facility and other public hospitals like us around the country, which have also seen increases in their indigent care burden.

How have we survived over the past 5 years? Well, we've absorbed a large part of this burden by increasing our productivity, and severely limiting our expenditures. This committee has had a long history of interest in cost containment. Let me tell you about some cost containment. Over the past 5 years the cost per case in the United States has increased at an average annual rate of 11.5 percent. Over that same period, our average annual increase has been held to one third that rate, or 3.8 percent, and last year it was only 1 percent. Behind these numbers are dramatic increases in productivity. We've slashed our number of employees per occupied bed by over 15 percent in the past 5 years.

Now, is this a success story that we should brag about, or have we paid a price for this stringent involuntary cost containment. I believe we've paid a price. And I fear that what's happening at our institution is also occurring at similar facilities which serve as the Nation's safety net.

During the first few years of declining resources we trimmed fat and increased productivity. But as we've continued to squeeze, the price we've had to pay is becoming quite apparent in a variety of ways.

We see that increased productivity has its limits and begins to lead at some point to a deterioration of service, and increased employee turnover. How long can you expect a nurse to provide high quality care when her unit is running 90 percent full and is staffed right at the margin? And how long can you retain that nurse when she can move to hospitals nearby which are running 60-percent full?

We see an increased rationing of critical care resources. Our ICU beds are consistently filled, and effectively rationed on an hourly basis with the least sick ICU patients being bumped out of ICU for the critical emergency admission.

We've seen an increased inability of our support services ranging from radiology through medical records to keep up with the burgeoning volume increase.

And finally, and most insideously, we've not been able to reinvest at an appropriate rate in plant and equipment.

I've described how we've absorbed the increasing burden of indigent care over the recent past. Let me tell you about right now. Our indigent care burden has increased by another 15 percent this year, and on top of that, we've been faced with a 300-percent increase, $1.7 million in our malpractice cost.

This twin blow led us to ask the city for a 20 percent increase in funding, an increase, frankly, the city is in no position to give us.

As a result, I'm faced with the need to cut 4 million more dollars from an already tight $80 million budget.

In this past week we've worked with great reluctance on a package to take the following steps.

Freeze cost of living employees for our employees the second year in a row. Close or drastically limit some programs in oral surgery, plastic surgery, obstetrics, laboratory, and x ray, and place a fee payable in advance on all of our services, even for those who meet every test of indigence.

These steps will further limit and restrict the care we can provide to our patients.

Mr. Chairman, let me turn from problems to solutions. If an overall solution to the plight of those who cannot afford health insurance in this country is beyond us for the present, there are critical steps we can take to protect the thread-bare safety net which public hospitals represent.

Truman Medical Center and many other core disproportionate share providers like us throughout the country, serve the most vulnerable of your medicare beneficiaries, the poor, aged, and disabled. Assisting us is crucial to assisting them, crucial to maintaining access to quality care for this most vulnerable group.

Our association would propose a straightforward program of Federal assistance to the most overburdened, disproportionate share hospitals in order to maintain access to care for those we serve.

Now I realize in this day and age you don't propose a program without a method of financing. I propose that such a subsidy be funded by setting aside 10 percent of savings flowing from any reductions in medicare and medicaid expenditures. If these programs must be cut, set aside some portion of the savings to aid the distressed institutions which serve your most needy beneficiaries.

Target such a program perhaps on the facilities with the highest proportion of disproportionate care; attach, if you would, any condition of efficiency or cost containment you choose; and insist that local government maintain their level of funding effort.

Now, some on this committee may ask why it would be appropriate to use medicare funds, even in this indirect fashion to subsidize these institutions. Come with me to my hospital or the other disproportionate share providers around the country and see the poorest of the aged and disabled who you and I are jointly responsible for, and you will see that there's a legitimate and, in fact, a compelling reason for medicare to assure access to quality care for its most vulnerable, needy, and disabled beneficiaries.

Thank you for the opportunity to testify in their behalf this morning.

Chairman STARK. Thank you very much, Doctor. Mr. Allison?

STATEMENT OF JOEL ALLISON, CHIEF EXECUTIVE OFFICER, AMARILLO HOSPITAL DISTRICT IN AMARILLO, ON BEHALF OF THE TEXAS ASSOCIATION OF PUBLIC AND NONPROFIT HOSPITALS

Mr. ALLISON. Mr. Chairman, and members of the Subcommittee on Health and the Committee on Ways and Means, my name is Joel Allison, and I'm the chief executive officer of the Amarillo Hospital District in Amarillo, TX, a large public teaching hospital in the Panhandle. I also serve as chairman of the Texas Association of Public and Nonprofit Hospitals, which represent 16 major hospitals in Texas, which are major providers of uncompensated care and/or teaching hospitals.

Briefly, our association represents 9.3 percent of all general hospital beds in Texas with a total of 6,718 beds. TAPNH hospitals accounted for nearly 12 percent of all admissions into Texas general hospitals.

I wish to impress upon the committee members today a real concern faced by our hospitals in being able to meet our mission of

caring for those patients who cannot pay during a time of severe competition and financial risk in the health care arena.

Hospitals, both public and voluntary, such as our membership, who are many times the only source of medical care for the poor, are in financial straits today because of a lack of funds to maintain their mission. The uninsured or uncompensated patient is not attractive in today's competitive marketplace, particularly in light of continued economic pressures and reduced funding at all levels of the government, as well as the private sector.

As an example, in 1981 an estimated 1.7 million Texans had no public or private health insurance. By 1985 just 4 years later, 2.7 million Texans were without health insurance.

The growth of the uninsured population in Texas is consistent with the trend seen nationally over the last decade. The number of Americans without health insurance increased from 28.7 million in 1979 to 32.7 million in 1982. Estimates of the uninsured population for 1985 exceed 35 million.

As in Texas, national increases in the uninsured population have been attributed to:

One, a failure of publicly financed programs that keep up with the growth of the poverty population;

Two, changes in health benefit coverage by firms seeking to reduce employee benefit costs;

Three, individuals being priced out of the individual insurance market; and

Four, changes in the economy with employment growth occurring in services, nonunion jobs, and part-time positions which are less likely to provide health insurance benefits.

The uncompensated care burden on the Texas hospitals was estimated at 1.2 billion for 1986.

The TAPNH member hospitals experienced a big increase in total uncollected revenues for 1983 to 1986. Our hospitals accounted for $598.49 million in total uncollected revenues in 1983 on total revenues of $1.139 billion. In 1986 that figure grew to $890.3 million in total uncollected revenues on total revenues of $1.79 billion by our members hospitals, an average of $63.6 million for TAPNH hospitals. Of those uncollected revenues, $513.5 million was eventually picked up by city, county, and State tax dollars. As is evident by this information, some hospitals bear a disproportionate burden because of their locations and their missions.

Hospitals in our association have been hurt by indigent care related actions. There have been service restrictions imposed. Technology has been cut back. Capital has been more difficult to acquire, and some have even had to divert private paying patients from their services because available beds are filled with the uncompensated patients.

Unfortunately, in Texas we have seen the extreme occur. Hospital closures. The Texas Department of Health informed me that since January 1, 1980, 85 hospitals in Texas have closed. One half of those hospital closures was due to financial difficulties. Since July 15, 1986, 18 hospitals have closed in Texas all because of financial problems.

Ten of those hospitals were sole community providers, and five were public hospitals. But it will be too late if Congress waits for

more hospitals to close before doing something to directly and financially assist the disproportionate share providers. Action must be taken now.

Texas studied the problem of indigent care and enacted legislation which included medicaid expansions, creation of local programs in the 125 counties that have not been doing much of anything, and targeted State programs for high risk pregnant women and low income individuals with limited access to primary care. Over $70 million in State funds, and $35 million in local funds were added to pay for indigent care.

Local city, county, and State tax support for TAPNH hospitals has increased over the 4 years examined. In 1983 the average hospital subsidy was $28.6 million. In 1986 that figure rose to $36.6 million.

For many years hospitals were able to cost shift to finance care for the uninsured. However, with the growth of a more competitive health care marketplace, hospitals have found it increasingly difficult to subsidize health care for the uninsured. In fact, many uninsured patients are now being shifted to the public hospitals and the voluntary hospitals still willing to care for the patient who cannot pay. But the safety net, the public hospitals and other disproportionate share hospitals is getting weaker as it is getting fuller.

There is an indication of the shifting of the uncompensated patient to the safety net hospitals. But I wish to stress again that this dangerous and burdensome trend cannot continue.

Clearly, our hospitals, like the uninsured receiving their care, face large financial burdens. This burden increases the potential for cutbacks in the needed community services in order to maintain the economic viability of the hospital despite the growing population who have need of those services.

It is imperative that direct Federal aid to the Medicare and Medicaid programs be afford to the disproportionate share providers of health care.

The safety net is stretched and is beginning to tear. Appropriate action on your committee's part can mend that net and allow the disproportionate share hospitals to meet their mission, but it cannot be done without your help.

Chairman Stark stated very well in his press release dated February 20, 1987, when he said "some of these public and voluntary hospitals are the only source of medical care for the poor. The survival of these hospitals is crucial for assuring needed care."

On behalf of the TAPNH membership, Mr. Stark, I want to say we agree wholeheartedly with you, and I want to also thank you for inviting me to appear before you today.

[The statement of Mr. Allison follows:]

TESTIMONY BEFORE SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON WAYS & MEANS
MARCH 12, 1987

Chairman Stark and members of the Subcommittee on Health of the Committee on Ways and Means, my name is JOEL ALLISON and I am the Chief Executive Officer of the Amarillo Hospital District in Amarillo, Texas. I also serve as Chairman of the Texas Association of Public and Nonprofit Hospitals which represents sixteen major hospitals in Texas which are major providers of uncompensated care and/or teaching hospitals. (Addendum I and Table I which are attached to my testimony give the specific characteristics of our member hospitals.) The Amarillo Hospital District and other members of our Association are also members of the National Association of Public Hospitals.

Briefly, our Association represents 9.3% of all general hospital beds in Texas with a total of 6,718 beds. TAPNH hospitals provided an average of 20,156 admissions per hospital in 1985 for a total of 282,188 admissions. TAPNH hospitals accounted for nearly 12% of all admissions into Texas general hospitals.

Addendum II which is attached and also includes Table II, gives the individual financial characteristics of 14 of the 16 members of TAPNH. I wish to impress upon committee members today, the real concern faced by our hospitals in being able to meet our mission of caring for those patients who cannot pay during a time of severe competition and financial risk in the healthcare arena.

Hospitals, both public and voluntary such as our membership who are many times the only source of medical care for the poor, are in financial straits today because of a lack of funds to maintain their mission. The uninsured (or uncompensated) patient is not attractive in today's competitive marketplace, particularly in light of continued economic pressures and reduced funding at all levels of government as well as the private sector.

As an example, in 1981 an estimated 1.7 million Texans had no public or private health insurance. (See Addendum III, January 26, 1987, article by Bryan Sperry, of the Family Health Resources, Office of Families and Children, Texas Department of Health. Changes in Texas Health Insurance Coverage: 1981-1985: Moving Toward A Less Insured Population.) By 1985, just four years later, 2.7 million Texans were without health insurance.

The growth of the uninsured population in Texas is consistent with a trend seen nationally over the last decade. The number of Americans without health insurance increased from 28.7 million in 1979 to 32.7 million in 1982. Estimates of the uninsured population for 1985 exceed 35 million.

As in Texas, national increases in the uninsured population have been attributed to:

1) A failure of publicly financed programs to keep up with the growth of the poverty population;

2) Changes in health benefit coverage by firms seeking to reduce employee benefit costs;

3) Individuals being priced out of the individual insurance market, and;

4) Changes in the economy with employment growth occurring in services, non-union jobs and part-time positions which are less likely to provide health insurance benefits.

The uncompensated care burden on the Texas hospital industry was estimated at 1.2 billion dollars for 1986 (Addendum III.)

The TAPNH member hospitals experienced a big increase in total uncollected revenues from 1983 to 1986. Our hospitals accounted for $598.49 million in total uncollected revenues in 1983 on total revenues of $1.139 billion. In 1986 that figure grew to $890.3 million in total uncollected revenues on total revenues of $1.793 billion for our members hospitals; an average of $63.59 million per TAPNH hospital (Addendum II.) Of those uncollected revenues, $513.5 million was eventually picked up by city, county and state tax dollars (see Table II.) As is evident by this information, some hospitals bear a disproportionate burden because of their locations and missions.

Hospitals in our Association have been hurt by indigent care related actions. There have been service restrictions imposed; technology has been cut back; capital has been more difficult to acquire; and some have even had to divert private paying patients from their services because available beds are filled with the uncompensated patients.

Unfortunately, in Texas we have seen the extreme occur --hospital closures. The Texas Department of Health informed me that since January 1, 1980, eighty-five hospitals in Texas have closed. One-half of those hospital closures was due to financial difficulties. Since July 15, 1986, eighteen hospitals have closed in Texas--all because of financial problems. Ten of those hospitals were sole community providers and five were public hospitals.

But it will be too late if Congress waits for more hospitals to close before doing something to directly and financially assist the disproportionate share provider, action must be taken now.

Texas studied the problem of indigent care and enacted legislation which included Medicaid expansions, creation of local programs in 125 counties that had not been doing much of anything, and targeted state programs for high risk pregnant women and low income individuals with limited access to primary care. Over $70 million in state funds and $35 million in local funds were added (plus some additional federal dollars through Medicaid) to pay for indigent care. (See Addendums IV and V.)
(Addendum IV: January 1987 Report from Texas Department of Human Services on Local Indigent Health Care Programs - Initial Implementation Assessment.)
(Addendum V: Annual Report of The Texas Department of Health Indigent Health Care Programs, submitted February 1, 1987.)

Local city, county and state tax support for TAPNH hospitals has increased over the four years examined in Addendum II and Table II. In 1983 the average hospital subsidy was $28.6 million. In 1986 the figure rose to $36.68 million.

For many years, hospitals were able to cost-shift to finance care for the uninsured. However, with the growth of a more competitive healthcare market place, hospitals have found it increasingly difficult to subsidize health care for the uninsured. In fact, many uninsured patients are now being shifted to the public hospitals and the voluntary hospitals still willing to care for the patient who cannot pay. But the safety net (the public hospitals and other disproportionate share hospitals) is getting weaker as it is getting fuller.

It is interesting to note that our TAPNH hospitals have maintained strong occupancy rates overall, compared to marked decreases in other general hospitals. For example, occupancy rates for TAPNH hospitals were 78.2%, 74.7% and 73.4% over the past three years--a rate of decrease of 4% from 1983-84 and of 1% from 1984-85. The figures for Texas general hospitals were lower (70.0%, 64.3% and 58.7%) and are decreasing at the faster rate of 6% per year.

This is an indication of the shifting of the uncompensated patient to the safety net hospitals. But I wish to stress again that this dangerous and burdensome trend cannot continue. Clearly, our hospitals, like the uninsured receiving their care, face large financial burdens. This burden increases the potential for cutbacks in needed community services in order to maintain the economic viability of the hospital--despite the growing population who have need of those services.

It is imperative that direct federal aid, through the Medicare and Medicaid programs be afforded to the disproportionate share providers of health care. Federal financial support is needed now for these hospitals because they have been willing to continue to meet their commitment to caring for patients who cannot pay. I urge you not to wait for more hospitals to close or for more patients to be turned away. Action is needed today. The safety net is stretched and beginning to tear. Appropriate action on your committee's part can mend that net and allow the disproportionate share hospitals to meet their mission. But, it cannot be done without your help.

Our disproportionate share provider hospitals serve the most vulnerable patients who are the poorest Medicare patients and often the sickest. We must have direct federal financial assistance to continue. Chairman Stark stated it very well in his press release dated February 20, 1987, when he said, "Some of these public and voluntary hospitals are the only source of medical care for the poor. The survival of these hospitals is crucial for assuring needed care."

On behalf of the TAPNH membership, I want to say we agree wholeheartedly with you and I want to thank you for inviting me to appear before you today.

Ed.--The following addendurs to this statement have been retained in committee files:

Addendum III - Changes In Texas Health Insurance Coverage: 1981-1985: Moving Toward A Less Insured Population. By Bryan P. Sperry and L. Carl Volpe, Ph.D. January 26, 1987.

Addendum IV - Local Indigent Health Care Programs. By L. Carl Volpe, Bryan P. Sperry, and Ernest P. Schmid. Texas Department of Human Services. January 1987.

Addendum V - The Texas Department of Health Indigent Health Care Programs Annual Report: Primary Health Care Services Act; Maternal and Infant Health Improvement Act; Special Supplemental Food Program for Women, Infants and Children; Hospital Patient Transfer; County Survey for the Indigent Health Care and Treatment Act; Hospital Reporting and Data Collection.

TABLE I

ADDENDUM I

CHARACTERISTICS OF TAPNH MEMBERS

Table I describes characteristics of the 16 members of the Texas Association of Public and Non-Profit Hospitals, comparing them to the statewide averages for general hospitals in Texas. (Source: The American Hospital Association). M.D. Anderson Hospital and University of Texas at Tyler, both specialty hospitals, were excluded in the calculations so that the figures could be compared to general hospitals statewide.

BEDS

The 14 general hospitals listed in Table I had an average bed size of 480 beds in 1985, ranging in size from 166 beds (Flow Memorial Hospital) to 971 (University of Texas at Galveston), for a total of 6718 beds. Over the three years examined, the number of beds remained relatively constant, with a slight increase between 1983-84 of 1% and a slight decrease between 1984-85 of 1%.

The average bed size for TAPNH hospitals was 478 in 1983, 484 in 1984 and 480 in 1985. The average sizes for general hospitals in Texas for these same years were 143, 145, and 147. TAPNH hospitals constituted 9.3% of all general hospital beds in Texas for all three years.

ADMISSIONS

TAPNH hospitals provided an average of 20,156 admissions per hospital in 1985, for a total of 282,188 admissions. Over the three years examined, there has been an increase in admissions of 2% from 1983-84 and of 1% from 1984-85. These admissions represent 10.4%, 11% and 11.9% of all admissions into Texas general hospitals for 1983, 1984 and 1985 respectively. Texas general hospital admissions declined during these years, by 4% from 1983-84, and by 7% from 1984-85.

The average number of admissions per hospital across all general hospitals in Texas in 1985, 4,861, was considerably less than the 20,156 for TAPNH.

AVERAGE DAILY CENSUS

Average Daily Census for TAPNH hospitals was 374 in 1983, 362 in 1984 and 352 in 1985, a rate of decrease of 3% each year. For Texas general hospitals, Average Daily Census figures were 101, 94, and 86 for the three years, which represents a much faster rate of decline (7% between 1983-84 and 10% between 1984-85).

OCCUPANCY RATES

Occupancy rates for TAPNH hospitals were 78.2%, 74.7% and 73.4% over the three years, a rate of decrease of 4% from 1983-84 and of 1% from 1984-85. The figures for Texas general hospitals were lower(70%, 64.3% and 58.7%), and are decreasing at the faster rate of 6% per year.

The 1985 TAPNH average also remains well above the U.S. community hospital average of 64.8% for that year.

BIRTHS

The number of births per TAPNH hospital has increased from 4762 in 1983, to 5004 in 1984, to 5355 in 1985. This is a rate of increase of 5% and 7%. The total births accounted for by TAPNH hospitals in 1983, 66,672, represents 23.3% of all births in Texas general hospitals, and this percentage increased to 24.7% in 1984 and to 26% in 1985.

TABLE I
CHARACTERISTICS OF TAPNH MEMBERS
And Comparison with State Hospitals: 1983-1985

HOSPITAL	CITY	BEDS 1983	BEDS 1984	BEDS 1985	ADMISSIONS 1983	ADMISSIONS 1984	ADMISSIONS 1985	AVG DAILY CENSUS 1983	AVG DAILY CENSUS 1984	AVG DAILY CENSUS 1985	OCCUPANCY RATE 1983	OCCUPANCY RATE 1984	OCCUPANCY RATE 1985	BIRTHS 1983	BIRTHS 1984	BIRTHS 1985
1 Amarillo Hosp Dist	Amarillo	382	382	392	15597	15823	15622	309	282	282	80.9%	73.8%	75.2%	2693	2865	2999
2 Brackenridge	Austin	358	389	387	18505	18491	17882	320	308	298	89.4%	79.2%	75.6%	2595	2893	3676
3 Parkland	Dallas	821	835	834	35536	33353	36227	677	659	684	82.1%	79.2%	82.0%	10468	11167	12572
4 Flow Mem. Hosp	Denton	166	166	166	6493	6514	6182	94	89	78	56.6%	53.6%	47.0%	1315	1466	1609
5 RE Thompson	El Paso	290	290	290	11344	12051	12142	170	173	164	58.6%	59.7%	56.6%	3034	3396	3872
6 Tarrant County JPS	Ft.North	353	353	327	14953	15671	16763	268	275	287	87.0%	77.9%	87.8%	4724	5011	6601
7 Univ Texas-Gal	Galveston	960	1042	971	27513	29731	31146	684	707	697	71.3%	67.9%	71.8%	5393	5969	5434
8 Harris County Hosp. Dist.	Houston	828	854	822	38806	40446	39665	733	665	655	88.5%	77.9%	79.6%	16392	17201	17050
9 Hermann Hosp	Houston	752	688	770	24778	25866	25762	626	597	578	82.0%	85.5%	78.1%	4147	4414	4774
10 MD Anderson*	Houston	507	507	507	14386	14099	14366	438	409	418	86.2%	80.7%	82.4%	0	0	0
11 Mercy Reg.Med.Ctr	Laredo	288	288	288	15259	15018	13721	234	226	200	83.3%	78.5%	69.4%	2553	2261	2419
12 Lubbock Co. Hosp. Dist.	Lubbock	244	256	297	10035	10994	10932	181	199	184	76.1%	78.0%	62.0%	2396	2474	2671
13 MidLand Co. Hosp Dist.	Midland	197	196	196	11043	11214	11048	159	154	144	80.7%	78.6%	73.5%	2365	2162	2326
14 Bexar Co. Hosp. Dist.	San Antonio	540	533	537	28220	28301	28309	432	385	384	80.0%	71.6%	71.9%	6779	7053	7099
15 Scott and White	Temple	514	509	441	16756	17282	16787	349	348	296	67.8%	64.1%	61.7%	1819	1726	1873
16 Univ Texas- Tyler*	Tyler	248	248	244	3834	4405	4367	161	146	129	64.9%	58.9%	53.0%	0	0	0
SUM		6693	6781	6718	274838	280755	282188	5236	5067	4931				66672	70058	74975
AVG		478	484	480	19631	20054	20156	374	362	352	78.2%	74.7%	73.4%	4762	5004	5355
# OF HOSPITALS	16															
PERCENT CHANGE			1%	-1%		2%	1%		-3%	-3%		-4%	-1%		5%	7%
% OF STATE TOTALS		9.3%	9.3%	9.3%	10.4%	11.0%	11.9%	10.4%	10.8%	11.7%				23.3%	24.7%	26.0%
STATE AVERAGES -(General Hospitals)		143	145	147	5304	5107	4861	101	94	86	70.0%	64.3%	58.7%	573	567	590
STATE TOTALS		71591	72695	72064	2651888	2553364	2376957	50397	46778	42269				286451	283678	288622
PERCENT CHANGE			2%	-1%		-4%	-7%		-7%	-10%		-6%	-6%		-1%	2%

OF GENERAL HOSP. 1983 500
1984 500
1985 489

* Figures for M.D.Anderson Hospital and University of Texas at Tyler were not used in calculations as these two hospitals are specialty hospitals.

SOURCE:American Hospital Association

TABLE II ADDENDUM II

TAPNH FINANCIAL CHARACTERISTICS

Table II describes the financial characteristics of 14 of the members of Texas Association of Public and Not-for-Profit Hospitals (Source: Individual Hospital Statistics).

TOTAL REVENUES

Total gross revenues, including operating, non-operating, and patient revenues were reported for the years 1983-1986. Total revenues for the average TAPNH hospital increased from $87,630,000 in 1983 to $128,120,000 in 1986. Over this time period, revenues increased, but at a declining rate. Percentage increase for 1983-84 was 18%, for 1984-85 it was 10%, and for 1985-86 it was 6%.

UNCOLLECTED REVENUE

Bad Debt/ Charity Care

The amount of bad debt/ charity care uncollected patient revenues has grown during the reporting period of 1984-1986. The average TAPNH hospital reported $49,600,000 of uncollected revenue attributable to bad debt/ charity care for 1984. This amount increased to $53,760,000 in 1985 and to $63,590,000, which is an increase of 11% from 1984-85 and 5% from 1985-86.

As a percentage of total revenues,bad debt/charity care accounted for, on average, 45.3% in 1984, 45.4% in 1985, and 44.8% in 1986. There was a wide range among the TAPNH hospitals reporting, with percentages ranging from 14.6% (Midland Hospital District) to 78.3% (Harris County Hospital District) for 1986.

Other Uncollected Revenues

Uncollected revenues, such as Medicare/Medicaid contractual allowances or discounted care represented an average of $4,160,000 per hospital in 1984, $4,910,000 in 1985, and $6,230,000 in 1986. This represents an 18% increase for 1984-85 and an increase of 27% for 1985-86.

Total Uncollected Revenues

Information on total uncollected revenues was available for 1983-1986. The average amount of uncollected revenues for TAPNH hospitals increased from $46,040,000 in 1983 to $63,590,000 in 1986.

For these hospitals, an average of 52.5% of revenues were uncollected in 1983, 49.2% in 1984, 49.5% in 1985 and 49.6% in 1986.

OPERATING EXPENSES

Over the 4 years reported, operating revenues at these TAPNH hospitals have increased, by 2% from 1983-84 and by 7% from 1984-85 and from 1985-86.

CITY/COUNTY/STATE TAX SUPPORT

Government tax support for TAPNH hopsitals has increased over the 4 years examined. In 1983, the average subsidy was $28,610,000, in 1984 it rose to $31,850,000, in 1985 it was $35,540,000, and in 1986 it was $36,680,000.

TABLE II
TAPNH FINANCIAL CHARACTERISTICS

		1 TOTAL REVENUES (in millions)				2 BAD DEBT/CHARITY UNCOLLECTED REVENUE+			3 OTHER UNCOLLECTED REVENUE+			4 TOTAL UNCOLLECTED REVENUES (in millions)				5 % REVENUES UNCOLLECTED			
HOSPITAL	CITY	1983	1984	1985	1986	1984	1985	1986	1984	1985	1986	1983	1984	1985	1986	1983	1984	1985	1986
1 Amarillo Hosp Dist	Amarillo	49.00	55.82	62.18	66.25	19.91	18.29	20.44	0.52	3.17	5.63	7.70	20.43	21.46	26.07	15.7%	36.6%	34.5%	39.3%
2 Bexar Co. Hosp. Dist.	San Anton	98.90	157.36	172.14	187.85	68.96	74.56	79.98	3.18	3.91	4.26	64.20	72.13	78.47	84.25	64.9%	45.8%	45.6%	44.8%
3 Brackenridge	Austin	78.10	85.96	91.79	97.99	20.75	30.61	27.21	4.27	7.20	8.14	13.90	25.02	37.81	35.35	17.8%	29.1%	41.2%	36.1%
4 Flow Mem. Hosp	Denton	16.84	17.74	21.38	21.95	3.09	3.99	4.94	1.35	2.01	2.36	4.91	4.43	6.00	7.30	29.2%	25.0%	28.1%	33.3%
5 Harris County Hosp. Dist	Houston	210.30	233.81	250.18	268.40	184.64	197.79	210.20	7.67	1.46	0.94	175.50	192.31	199.25	211.13	83.5%	82.3%	79.6%	78.7%
6 Hermann Hosp	Houston	170.83	190.96	208.64	220.63	27.24	30.25	37.30	9.52	18.33	18.19	36.69	36.76	48.58	55.49	21.5%	19.3%	23.3%	25.2%
7 Lubbock Co. Hosp. Dist.	Lubbock	47.50	62.09	67.38	72.46	18.34	20.75	18.31	5.42	6.19	8.43	17.20	23.76	26.93	26.74	36.2%	38.3%	40.0%	36.9%
8 MD Anderson	Houston		184.48	212.25	210.39	35.92	42.41	36.08	0.13	0.24	3.02		36.05	42.65	39.10	ERR	19.5%	20.1%	18.6%
9 Mercy Reg.Med.Ctr	Laredo	32.72	39.70	40.08	43.83	6.32	7.04	6.50	7.37	6.33	7.79	9.51	13.69	13.37	14.29	29.1%	34.5%	33.4%	32.6%
10 MidLand Co. Hosp Dist.	Midland	33.65	40.73	45.48	49.59	6.31	7.41	7.27	2.11	2.94	5.63	6.28	8.42	10.35	12.90	18.7%	20.7%	22.8%	26.0%
11 Parkland	Dallas	179.90	199.30	231.74	250.96	128.38	151.86	169.03	11.17	10.45	9.89	122.40	139.55	162.31	178.92	68.0%	70.0%	70.0%	71.3%
12 RE Thompson	El Paso	41.20	46.19	53.93	59.65	30.37	33.74	35.80	3.54	5.11	5.86	30.30	33.91	38.85	41.66	73.5%	73.4%	72.0%	69.8%
15 Univ Texas- Tyler	Tyler	18.00	21.93	25.44	29.79	8.87	10.91	13.37	1.10	0.08	0.60	11.00	9.97	10.99	13.97	61.1%	45.5%	43.2%	46.9%
16 Univ Texas-Gal	Galveston	162.20	195.11	207.09	213.89	135.26	138.01	136.64	0.90	1.35	6.47	98.90	136.16	139.36	143.12	61.0%	69.8%	67.3%	66.9%
TOTAL		1139.14	1531.17	1689.69	1793.64	694.35	767.61	803.08	58.25	68.78	87.21	599.49	752.60	836.39	890.30				
AVERAGE		87.63	109.37	120.69	128.12	49.60	54.83	57.36	4.16	4.91	6.23	46.04	53.76	59.74	63.59	52.5%	49.2%	49.5%	49.6%
% CHANGE*			18%	10%	6%		11%	5%		18%	27%		20%	11%	6%		-3.4%	0.3%	0.1%
		13	14	14	14	14	14	14	14	14	14	13	14	14	14	14	14	14	14

* Percent change calculations for 1983-84 excluded M.D. Anderson Hospital, for which 1983 information was unavailable

+ Information on uncollected revenue for 1983 was available only in aggregate, therefore no figures are listed for BAD DEBT/ CHARITY CARE UNCOLLECTED REVENUES and OTHER UNCOLLECTED REVENUES.

TABLE II con't
TAFNH FINANCIAL CHARACTERISTICS

		6 OPERATING EXPENSES (in millions)				7 CITY/COUNTY/STATE TAX SUPPORT (in millions)				8 % OF REVENUES CHARITY/BAD DEBT		
HOSPITAL	CITY	1983	1984	1985	1986	1983	1984	1985	1986	1984	1985	1986
1 Amarillo Hosp Dist	Amarillo	38.90	40.89	46.98	49.92	7.30	8.54	9.00	9.69	35.7%	29.1%	30.9%
2 Bexar Co. Hosp. Dist.	San Anton	75.40	78.55	86.82	95.02	34.30	43.72	48.64	56.23	43.8%	43.3%	42.6%
3 Brackenridge	Austin	61.00	67.23	72.48	68.21	12.00	8.40	11.77	11.63	24.0%	33.0%	28.0%
4 Flow Mem. Hosp	Denton	12.94	13.65	13.38	14.69	0.23	0.74	1.15	0.65	17.4%	18.7%	22.5%
5 Harris County Hosp. Dist	Houston	152.30	157.79	166.06	179.32	122.60	143.95	148.59	153.64	80.0%	79.0%	78.3%
6 Hermann Hosp	Houston	130.38	132.98	144.35	159.51	0.00	0.00	0.00	0.00	14.3%	14.5%	16.9%
7 Lubbock Co. Hosp. Dist.	Lubbock	32.50	38.56	39.70	44.04	4.80	5.67	5.78	5.54	29.5%	30.8%	25.3%
8 MD Anderson	Houston		163.61	169.54	180.04		53.04	66.70	62.08	27.3%	29.1%	24.3%
9 Mercy Reg.Med.Cntr	Laredo	22.38	24.38	24.90	27.51	0.00	0.00	0.00	0.00	15.9%	17.6%	14.8%
10 MidLand Co. Hosp Dist.	Midland	29.68	31.34	34.81	40.95	2.50	2.80	3.19	3.38	15.4%	16.2%	14.6%
11 Parkland	Dallas	123.20	128.41	145.83	160.73	64.70	81.20	87.46	95.29	64.4%	65.5%	67.4%
12 RE Thompson	El Paso	24.00	25.80	29.43	31.02	10.40	13.63	14.21	15.60	65.7%	62.6%	60.0%
15 Univ Texas- Tyler	Tyler	23.50	23.80	27.32	27.89	14.80	9.77	11.83	12.05	40.4%	42.9%	44.9%
16 Univ Texas-Gal	Galveston	181.00	156.70	162.30	171.11	98.30	74.49	89.19	87.72	69.0%	66.0%	64.0%
TOTAL		906.18	1083.70	1163.91	1249.95	371.92	445.94	497.51	513.50			
AVERAGE		69.71	77.41	83.14	89.28	28.61	31.85	35.54	36.68	45.3%	45.4%	44.8%
% CHANGE*			2%	7%	7%		6%	12%	3%		0.1%	-0.7%
		13	14	14	14	13	14	14	14	14	14	14

Chairman STARK. Thank you very much, Mr. Allison. Mr. Connors?

STATEMENT OF EDWARD J. CONNORS, PRESIDENT, MERCY HEALTH SERVICES, FARMINGTON HILLS, MI

Mr. CONNORS. Thank you very much, Mr. Chairman.

I am Ed Connors, president of Mercy Health Services, in Detroit, MI, and I want to shift the emphasis of our attention to the private and voluntary sector of sharing many of the experiences of my previous two colleagues who have spoken.

We are a voluntary, not for profit, religiously sponsored system of institutions and programs. We serve in 26 communities in the States of Michigan, Iowa, Indiana, and New York. The population that we serve in these 26 communities numbers about 5,300,000 people, and our particularly not-for-profit service includes a system owned and managed hospitals, nursing homes, ambulatory care centers, health maintenance organizations, and auxiliary health services.

We have about 5,600 acute beds, and about 18,000 employees. Our service is very diverse from urban, metropolitan areas, such as Detroit, where there is in effect no public hospital, to small rural institutions, particularly in the State of Iowa.

Our service is permanent. We've been serving since 1879 in the United States, and we believe our services contemporary in every respect with regard to quality, to management, and like Jim, we would welcome any opportunity to demonstrate that our financial experience, which I'm going to share with you, is not the result of sloppy management.

Why we serve and why we're concerned about this subject I think stems in our case from our Christian heritage and a set of values that motivates us to be of service to the economically poor. We do believe that all persons have an inherent right to needed health and medical care, and it is up to the public and private sector together to see to it that that right is not abrogated in the way we organize and the way we finance, and the way we would deliver such care.

Thus, we feel very deeply about our obligation to society, and the not for profit motives that have dominated our service.

Indigent care is a problem. It's a problem to us, and it's a growing problem. It's a reality that I think is well understood by this committee.

I was privileged to serve on both the American Hospital Association and Catholic Hospital Health Association, special efforts last year to document the scope of this problem. And as you know, those two publications, no room in the marketplace by CHA, and cost in comparison by AHA, clearly documents the scope of the problem, and I'm not going to review those figures today, but I do want to share with you some of our own experience.

Our own charity care in the Sisters of Mercy is significant and it is growing. In 1986 as a system we had $8.6 million worth of charity care, and that figure has doubled since 1980.

If you compare that to our total net income from operations, that is, our excessive income over expense from operation which was

$12.1 million, you can see that charity care is 67 percent of our bottom line from operations.

Even when you add in our income from investments and philanthropy, that $8.6 million of charity care, compares to $29.4 million of total bottom line, or 23 percent of all of our surplus. That percent was 13 percent in 1960. So it's gone in a relationship way from 13 to 23 percent in that period of time.

Bad debts are increasing significantly. We have $31 million worth of bad debts in the Sisters of Mercy system. And I can assure you that is not because of the sloppy management, but it is because of the lack of the financial capability of those persons that we serve that either have no insurance, they do not qualify for medicaid, or they are underinsured.

It is becoming more difficult for us to sustain our commitment to serve the indigent. Changes in payment by both government and the private sector are squeezing our ability to provide an excess of income over expense because no payer seems to be willing to continue to subsidize charity care.

Employers through PPO's are depending upon lowest prices. HMO's are intended to cover only their subscribers and so on.

I want to highlight for this committee that Medicaid is not paying full cost of care. It is our estimate that Medicaid payments which represent 12 percent of all of our revenue are under our actual cost by 10 percent for inpatient care, and about 30 or 40 percent on outpatient care.

The populations that we serve in Michigan and Iowa particularly, and Indiana, are dominated by three major industries, auto, steel, and farming. All have chronic and significant challenges to face, and unemployment and loss of benefits are an increasing problem.

What are we trying to do? Despite these worrisome financial results, we have attempted to back our commitment to serve the indigent with action, and let me quickly share four quick things.

Our decision to stay in the ity of Detroit as late as 1984 cost us a replacement facility of $86 million. We were forced to abandon our inpatient service facilities in Detroit because of a General Motors City of Detroit building program for a new autoplant.

Second, we have instituted since 1979 five what we call primary care initiative facilities. In these five multidisciplinary ambulatory care centers, we're providing comprehensive and continuous medical care, dental care, nutrition, and social services, and health education.

Since 1979 in these five ambulatory centers we have served over 440,000 patient encounters. Our operating budget per year for those centers is $7 million. We get $3 million from the Federal Government; $2 million in charity care, and $1.4 million are bad debts in those centers. Hardly a break even situation.

Our challenges also include those problems that are facing rural hospitals. Our presence in Iowa accounts for about 20 percent of the acute inpatient beds in that State. And this committee is well aware of the inadequacies and the inequities in the current Medicare payment for rural hospitals, a matter that needs prompt attention by Congress.

Now, challenges and problems are easier to share than constructive solutions. In my written testimony I've commented on some policy and directions for the future, and they include, first, to promote options to expand private health care coverage in the private sector to cover all employed individuals and their dependents.

Second, in our opinion, to strengthen and expand the Federal involvement in medicaid aimed at achieving an improved uniform standard of eligibility, and the creation of a stable and dedicated source of funding.

I recognize that this must be done as Federal sources permit, and requires hard choices now and in the future. Congressional intervention is required to make health care coverage for all employees' independence a reality.

Third, we encourage the development of high quality not for profit, managed care systems into which medicare and medicaid recipients can be enrolled on a capitated basis, and treated in the mainstream of the public and private hospital and medical care system.

And fourth, to enable the Federal Medicare program to finance long-term care, to finance home health services, and catastrophic illness. Thus, reducing the financial burden on the Medicaid program that was designed initially to serve the indigent nonaged population.

I want to close with a note of optimism. The public and the private sector must work cooperatively together to solve this problem. Solutions are likely to be incremental. We understand this, but solutions must be found if we are to consider ourselves a part of a just society.

Mr. Chairman, I thank you for the chance of coming.

[The statement of Mr. Connors follows:]

Statement of Edward J. Connors, Mercy Health Services

Introduction

Mr. Chairman and members of the Subcommittee, I am Edward J. Connors, President of Mercy Health Services, a nonprofit provider of health care services. I am deeply appreciative of this opportunity to testify here today.

Mercy Health Services is a sponsored work of the Sisters of Mercy, Province of Detroit. Under its aegis are health care facilities in Iowa and Michigan, as well as in Indiana and New York. The largest subsidiary of Mercy Health Services, the Sisters of Mercy Health Corporation, includes a system of 23 health care facilities including hospitals, nursing homes, health maintenance organizations, and ancillary health services. Our hospitals, which include a complement of 5,700 acute beds, extend from the inner City of Detroit to rural Iowa. The first Sisters of Mercy hospital in Michigan that is still in operation today was founded in 1893. Mercy Health Center in Dubuque, Iowa, was founded in 1879.

The Religious Sisters of Mercy as our sponsor work at all levels of the Corporation -- through governance of our institutions, as staff directly involved with patient care, and by setting forth the vision that is the nexus for the future direction of our Corporation. The Sisters of Mercy have also consciously and assertively involved committed lay persons at all levels of the Corporation. In this way, the Corporation becomes a living witness to the values of a Christian healing ministry.

Let me take a moment to excerpt and share with you the Vision Statement that the Sisters of Mercy have set forth for the Corporation: "We will... contin[ue] to be faithful to our charism of mercy through service to the poor, sick and uneducated, giving priority to those who are economically poor." This contemporary expression of the ministry permeates the entire operation of Mercy Health Services.

I wish to commend you and your Subcommittee for having these Hearings. It was not long ago that I and my colleagues at the American Hospital and Catholic Health Associations believed there was no public understanding that there was even a problem of financing health care for the poor. Nor, of course, was there any effective voice for the uninsured.

Bringing these issues to the fore through these Hearings indicates the public realization that there is a problem, and I believe these Hearings will begin the necessary public debate of determining how best to finance health care for the vast, and growing, number of our citizens who lack reasonable access to needed health care services.

Response to the Challenge of Caring for the Poor

I am certain that you have heard, often enough, that competition among hospitals and health care providers has increased significantly in recent years and that such competitiveness may often reduce the price of services provided to the community. However, this trend coupled with the growing influence of major purchasers who want to cut their health care expenditures has reduced the ability, and often the willingness, of hospitals and other health care providers to serve the poor. Simply put, as hospital revenues decrease, those responsible for governing and managing hospitals have fewer resources available to appropriate to the care of the poor.

I, the Mercy Health Services Board, and our health care institutions wrestle with this struggle daily. All members of the Mercy family know that its contemporary commitment is to provide a nonexclusive preferential option to serve the poor. Yet we admonish the chief executive officers of our institutions to operate in a prudent and careful manner that preserves the financial stability of their organizations, so that they can truly serve the poor and meet the health care needs of their respective communities. This balance is becoming more and more precarious.

At no point did these potentially clashing objectives come together more than in the decision to build Samaritan Health Center in Detroit. In 1977, our hospital property found itself in the path of the new General Motors Poletown plant. Facing the prospects of condemnation forced us to soul search whether we would continue our ministry in the inner city, or seek to place our investment in an area where we could be assured of a patient base that was able to provide adequate remuneration for the health care services rendered.

We chose not only to reaffirm our commitment to our service area in the inner city of Detroit, but to expand the scope of our services and to enhance our primary care services to individuals who heretofore were without any access to needed health care services.

Samaritan, a 375-bed acute hospital, was completed in 1984 at a cost of $86.6 million. About 18% of the total debt service of the Corporation is dedicated to providing health care services in this inner city area. Indicators abound on the need for primary care in the Samaritan service area, but perhaps the most striking, and concerning, is the area's high infant death rate of 22 per 1000 live births. This compares to an overall U.S. infant mortality rate of 11 per 1000 live births.

Recognizing that primary health care was a sorely unmet need in this service area, five primary care service facilities were also provided to residents in this area of Detroit. A sixth site is in the planning stages. These primary care service centers are close to Samaritan Health Center and not far from Mt. Carmel Mercy Hospital, our other hospital in the City of Detroit.

While I don't pretend that Samaritan Health Center and these primary care facilities serve all of the unmet health care needs of its service area, I will note that there were 88,000 visits to these primary care facilities this past year. These primary care facilities deliver health services that undoubtedly would not be available in the absence of these facilities. With only a token amount received from those needing the benefits of these services, the entire Mercy Health Services system must, through higher costs, reduced capital investment, and added efficiencies, support this commitment. I would note that Samaritan Health Center costs are favorable compared to other providers in its service area.

Much has been written about the overwhelming burden of indigent care incurred by publicly-owned hospitals. Data provided to me by your Subcommittee indicate that public hospitals provide 40 percent of the uncompensated care in the United States. The private nonprofit hospital tradition in Michigan is very strong and only a relatively small percentage of the hospital beds in the State are publicly owned. Hence, were it not for the strength and commitment of the voluntary hospital system in the State of Michigan, there would not be any source of care for low-income individuals who do not have any means of paying for their care. This is not to say, however, that the government agencies in the State have not made a commitment to health care coverage. Currently, the State of Michigan's Medicaid budget totals over $1.6 billion on an annual basis, about 15 percent of the State's total budget.

Another dimension to our system's service to the poor involves the need to serve the growing legions of rural poor, especially in our Iowa service area. While slightly over 50 percent of our acute beds are in Michigan, our Iowa presence accounts for 20 percent of the acute beds in that State. Identifying, reaching out, and determining how our health care system can best assist these individuals currently in need is one of the contemporary challenges of our system. Our Iowa hospital divisions have always had programs to serve the poor, but this ministry commitment is, of necessity, undergoing significant expansion.

Within our Corporation is a fund that is utilized to provide seed money for new programs that directly serve the poor; of this year's allotment, $40,000 has been provided to three of our Iowa hospitals to develop an initiative for the rural poor in those service areas. While the program will not even begin to meet even the most rudimentary health care needs of the poor in this area, it will enable us to develop and to determine what new initiatives will meet the unmet health care needs of these individuals. In addition, this investment will teach us what services we can provide most efficiently and effectively to this population.

Like many health care providers, we view the development of HMOs as a sound alternative to fee-for-service that can support cost effective, high quality services. Because we believe this option should be widely available to all individuals in our service area, we have formed several HMOs and they are actively exploring the option of enrolling Medicaid beneficiaries in their programs.

Our Recent Challenges in Providing Health Care to the Poor

In the past five years, we have been faced with an ever-increasing surge in bad debts, greater demands and need for charity care, and an even larger population who come to us only when their needs are so severe that they risk long-term disability and ongoing health problems.

The pressing demands on our system are reflected in a more than doubling of charity care between 1980 and 1986 and a more than tripling of the amount of bad debts over the same six-year period. In 1986, our charity care totalled $8.6 million, while bad debts reached $31.3 million. Charity care as a percent of net income tells perhaps the most dramatic story. In 1980, when our health care system was still essentially a cost plus system, charity care as a percent of net income totalled 13 percent. As we have more and more faced a buyers' market and concomitant cost pressures and intense competition, that figure surged to 29 percent in 1986. With charity care added back into net income, the comparable figures are 12 percent and 23 percent for 1980 and 1986, respectively.

Not surprisingly, as more and more individuals are without adequate health care coverage -- even those who are working full time -- bad debts have increased across our system, even in areas where employment has been stable or growing. A natural response to the recent surge in bad debts, is why don't you do a better job of collecting on your accounts receivable? A fair question, and our Trustees have directed management to better police and secure payment, where possible, of these bad debts.

We have found, however, that there is a fine line between bad debts and charity care. While we have not fully analyzed the increase in the difficulty we have faced in attempting to collect these debts, it is my firm belief that an increasing proportion and amount of these bad debts are incurred by individuals who do not have adequate health care coverage and who visit our facilities only when their needs are acute, and mount up bills that they have severe difficulty in amortizing. The growth in bad debts has been systemwide.

We applaud the recent initiatives of Congress to meet the needs of the poor by providing a reimbursement increment to hospitals providing disproportionate amounts of care to the poor. Samaritan Health Center received incremental Medicare funding of about $300 thousand as a result of this provision of the Omnibus Reconciliation Act from July through January. We also believe that the recent amendments to the Social Security Act, which give states the opportunity to expand Medicaid benefits to certain low-income pregnant women and children, were sound and will target funds at unmet needs. We are actively arguing for adoption of these widened eligibility requirements in the states in which we operate. Michigan has incorporated into its Medicaid formula an adjustment that increases reimbursement for hospitals having a large indigent care burden.

1987 and Beyond

Our Board, despite the exigencies and pressures of the current situation, has reaffirmed its plans to continue to provide health service to the economically disadvantaged and the poor. We recognize that our commitment is to the total community in which we operate and that to effectively serve the poor, we must make an attempt to impact the total human service needs of these areas. The Catholic Health Association's Task Force on Health Care of the Poor in its recent publication No Room in the Marketplace: The Health Care of the Poor, recommended that all Catholic multi-institutional systems provide in their annual planning processes a commitment to providing charity care, among other recommendations.

While we have consistently provided an explicit and budgeted amount of charity care, we do not have, in monetary terms, any good estimates of the true quantitative value of all the charity care and health-related community services we provide other than what we have narrowly defined in our accounting system. We are working with the Catholic Health Association and our own accountants in order to make a precise quantitative accounting of these services our institutions are providing. Our hospitals have numerous programs for seniors and low-income individuals that are run by volunteers in conjunction with the professional staff of the hospital. These community-wide health promotion activities likely provide access by the poor to health care.

By assessing internally our own commitment by proper and accurate measurement, we will be able to better gear our own institutions to meet the challenges of the nineties and beyond.

Not only are we in the process of attempting to accurately compile the scope of the services we provide but, programmatically, I have formed within Mercy Health Services our Special Initiative for the Poor. This effort is concerned with how we can network, leverage resources, and coordinate services in order to best reach more low-income individuals with the resources that we have and assure that the values of the Sisters of Mercy are reflected in all of our hospitals' services.

This Special Initiative for the Poor builds on a 1985 Sisters of Mercy Health Corporation publication entitled Health Services for the Poor: A Challenge to Public Policy, which establishes our guiding public policy principles that would enable service to the poor. The principles are as valid today as they were in 1985.

I believe, as this publication puts forth, that the pluralistic nature of the American health care system, which includes a blending of individual, public, and private funding should be maintained. We must, within this system, ensure that we are not building a two-tiered, or as some have suggested, a three-tiered health care system, each with a different degree of accessibility and quality of care. The poor should not be relegated to only those facilities willing, or forced by law, to take them.

Equitable access by all to needed health care services is, however, becoming a strain as the health care needs and demands of the poor are becoming beyond our means to support, and simultaneously provide high quality health care.

Reforms Needed

Mr. Chairman, I recommend that your Committee strongly consider the following:

1. Review options to expand health care coverage in the private sector to all employed individuals and their dependants. I fully realize that the Federal Government provides private employers with $35 billion in Federal tax incentives to provide health care coverage for employees. About 18 million people under age 65 completely lack health care coverage while another 16 million are uninsured for part of a year. Congressional intervention is required to make health care coverage for all employees a reality. Lowered marginal tax rates for corporations and individuals may have reduced the incentive/increased the cost for business corporations to provide health care coverage. At the same time, the incentive to employees to request that employers provide health care has been reduced, since increased wages -- the alternative to health care coverage -- may be more attractive to employees under the new lowered marginal tax rates. Likewise, the incentive to private philantrophy as a source of providing health care for the poor has been diminished by tax law changes. While it is well known that philantrophy as a source of funding health care costs has dwindled drastically, our needs have required us to strengthen philantropic fund-raising activities. Mercy Health Services recently formed the subsidiary, Mercy Health Foundation, to enhance our abilities to raise funds to provide health care services through giving.

Congress, of course, has numerous methodologies open to it to assure an increase in the number of individuals provided health care coverage by the private sector. It can directly mandate minimum benefits for each employee and his or her dependents, or it can delegate to the states the option to mandate. I prefer that Congress directly mandate so that employees, no matter where their residence, be availed of the ability to be provided health care coverage.

In order to structure benefits so that health care services will be provided efficiently and at the lowest cost possible, benefits should be structured with reasonable co-pays and deductibles, yet provide coverage for catastrophic costs. Managed care options should be available to all employers so that care is delivered as efficiently as possible and so that primary health care needs are met in a systematic manner. Minimum benefits should be the actuarial equivalant of what Medicare now provides. As with the Medicare system, employees could be mandated by Federal law to provide partial payments

for the benefits provided. Employers should be prohibited from age rating and imposing onerous pre-existing conditions exclusions.

2. A federalized system needs to be developed to provide health care access to the low-income nonaged that could build upon the current Medicaid system. Such a mechanism should be financed through payroll taxes that are allocated to an indigent care trust fund. This mechanism will eliminate the discontinuities in the current system of eligibility for government-assisted financing.

3. Move Medicare towards a voucher system. A voucher approach for the elderly, properly implemented and regulated, would widen the choices that the elderly have in securing health care services with concomitant increases in quality. Movement towards the entitlement of long-term care services should follow after Medicare is transitioned into a voucher system.

4. Develop managed care systems for Medicaid and Medicare into the private system of delivery. Strong private sector participation will provide the unemployed and uninsured with a capitated plan of their choosing, putting them on equal footing with those having a private means of funding their services.

Chairman STARK. Thank you.
Ms. Brown.

STATEMENT OF ANN BROWN, ADMINISTRATOR, JEFFERSON COUNTY HOSPITAL, FAYETTE, MS

Ms. BROWN. Mr. Chairman, and members of this subcommittee. My name is Ann Brown. I'm the administrator of a 30-bed county hospital located in southwest Mississippi.

I appreciate the opportunity to appear before this subcommittee because I believe the issue of finding adequate resources to fund health care services for the indigent and medically indigent is one of the most urgent problems facing the nation.

The provision of health care for the poor affects both the public and private sectors. My purpose here today is to describe the critical financial situation facing my hospital and other rural hospitals.

We are an institution that delivers health care services to the poor also. We appreciate the subcommittee seeking the rural perspective, and its recognizing that the indigent care is not just an urban problem.

Let me tell you a little bit about my facility.

Jefferson County Hospital, the 30-bed short-term acute care hospital located in Fayette, MS, exemplifies a small rural facility that is struggling to provide health services to an increasing number of indigent patients despite the eroding support at the time of recession in rural America. We are a facility seeking to provide a limited range of general medical services. We operate a short-term acute care hospital. We operate an emergency room department, an ambulance service, and we offer postacute care through the swing bed program.

The resolution of indigent care question is crucial to our survival.

We live in a community of about 9,000 people in the entire county. In the terms of income, 41 percent of our county residents are below the Federal poverty level. In terms of unemployment last year we exceeded 20 percent. The hospital's employment and payroll is very important to our county. We're one of the largest industries in Jefferson County. Our payroll is absolutely essential to fuel the local economy. We're big business for Jefferson County and for many reasons a very important business.

In the 1940's and 1950's the Hill-Burton thrust was such that we could have access to health care for rural citizens. Now we have a hospital that is a Hill-Burton hospital, and we have more than satisfied our obligation.

We need to do something now to support these Hill-Burton hospitals in order to continue to provide health care for rural America. There is a need to have access to health care in facilities that have limited general medical services.

The treatment of the illnesses in our hospital are for the primary health diseases; heart disease, diabetes, hypertension, and chronic obstructive pulmonary disease. We have a very limited OB service. We only had 28 babies born in our hospital last year. In the 5 months of this year we only had 6.

We provide, as I said, the emergency room services, and ambulance services. We have to have the capability of triaging and stabilizing emergency cases so they can be shipped to a larger hospital.

I'd like to offer a few patient care statistics.

Last year, we had 1,600 outpatients, and 2,900 emergency room visits. Our inpatient occupancy rate was right at 65 percent. Of our patient days of care, almost 40 percent were Medicare, 17 percent Medicaid, 6 percent swing beds, and 36 percent were either private or unpaid bills.

The average length of stay in our hospital is 5 days. That is less than our State's average.

Our 1986 budget was in excess of $2 million and our uncompensated care was $210,000. Our tax subsidy was $40,000 last year, but because of the decline in revenue sharing funds, the county is only going to give us $30,000, which does not even make one payroll.

We have no alternate but to fund our net patient deficits out of our reserves. Two years ago we had a million dollar reserve, but now we're down to $600,000. At this rate we're going to be out of business in 3 years.

The matter of providing uncompensated care is a critical one, and something has to be done. It doesn't take an "Ole Miss" business degree to realize that you cannot deplete the resources of a facility like ours and not break even and survive.

Jefferson County Hospital is a Medicare disproportionate share hospital, but the adjustment is not meant for or sufficient to fund indigent care. The Medicaid program is totally inadquate in Mississippi. The solution of increasing revenues from non-patient-related sources and reducing expenses, through cost containment is imperative.

The question today is becoming can rural hospitals provide the good care that is expected of them and contain costs at the same time. How cost efficient can we be and not compromise patient care?

You know, care is not a product that can be measured in cost like the wheat in a loaf of bread. Unlike most business operations, there's no systematic method for a hospital to follow to evaluate the end product, which is whether or not the patient gets well and stays well. When someone is sick they're not overly concerned about the cost of the care. They want the best.

Jefferson County Hospital has a public responsibility to care for the sick in the most efficient and effective means possible.

We perform this service every day, and in doing so we come face-to-face with the issue of uncompensated care that I mentioned in the beginning.

As the administrator of our hospital, I see the ripple effect with the cost-containment efforts. In 65 percent of our cost is employee-related cost. The reduction of Medicare and Medicaid is followed by a decrease in staff. It leads to further depression in our local economy resulting in an erosion of the tax base.

I can testify to the fact that Jefferson County Hospital's mission and existence is threatened due to financial stress. If we cannot find new and additional means to pay for the rural hospitals for its uncompensated care, it will be impossible to maintain the present standard of medical care, impossible to replace equipment and

maintain our facility. It will be impossible to retain highly trained personnel that is necessary in today's high technical medical care.

It will be impossible to pay for goods and services necessary for the survival of this institution. I'm not talking to you about what might happen to us in a decade or so. I'm talking about what is going to happen this year or within the next 2 or 3 years.

You might be thinking it ought to be more efficient to reduce the staff, or cut out the fat. We are right down to the bone now. Last month we were surveyed by our licensing agency, and they remarked on the efficiency of our operation, and the high standards of medical care we offered. We are doing everything possible to have top notch organization. Still we look at these staggering amounts of uncompensated care and know the wolf is at the door. Our hands are tied. We must appeal to Federal, State, and county entities to alleviate the strain.

Not to respond to this juncture is to pronounce a death sentence on many rural hospitals that bear the financial burdens caused by caring for the medically indigent. We need your help and support.

Thank you for letting me testify.

[The statement of Ms. Brown follows:]

STATEMENT
OF
ANN BROWN,
ADMINISTRATOR, JEFFERSON COUNTY HOSPITAL,
FAYETTE, MISSISSIPPI,

Mr. Chairman and members of the Subcommittee, my name is Ann Brown. As the administrator of a 30-bed county hospital located in rural Mississippi, I appreciate the opportunity to appear before this Subcommittee because I believe that the issue of finding adequate resources to fund health care services for the indigent is one of the most urgent problems facing the nation. My purpose here today is to describe the critical financial situation facing my hospital as a member of the rural hospital community and as an institution which delivers health care services to the poor.

OVERVIEW OF THE PROBLEM

As a result of the recent recession in the rural agricultural, timber, and mining industries, there are millions of rural Americans for whom access to and the ability to pay for health services have become serious problems. Many communities no longer have viable business districts, as local businesses and factories are being forced out of business, and many farms are going bankrupt and being repossessed. Not only have many rural residents been unable to contribute to the philanthropic support of their local hospitals' services to the poor, but they also have not been able to pay for needed medical or hospital care for themselves and their families, or even for essential primary health insurance coverage.

Before I tell you about my hospital, I would like to correct what I believe is a misconception concerning indigent care. The provision of indigent care is not just an urban problem, but an urgent and rapidly increasing concern for rural hospitals which provide care for the rural poor. Let me share with you some information about the uninsured rural poor and about rural hospitals as a group.

Of the 37 million uninsured, 10.6 million live in rural America. In 1982, 35.5 percent of the nation's rural hospitals reported spending the equivalent of 5 percent or more of total charges on uncompensated care--charity care and bad debts--compared with 25.5 percent of metropolitan hospitals and 30.1 percent of urban hospitals. In 1984, only 25 percent of all hospitals had uncompensated care levels above 6.2 percent of costs, while 39.3 percent of all public general hospitals had such levels.

Although Medicaid is often thought of as the principal means of financing care for the indigent, it now covers less than 40 percent of the poor. Medicaid must now be viewed principally as a program of supplementary coverage for the aged and disabled medically indigent who are eligible for and receive benefits under Medicare.

At the same time Medicaid has been providing coverage for a declining percentage of the poor, the amount of uncompensated care provided by hospitals has risen sharply. State and local government tax appropriations have not kept pace with the growth in uncompensated care. As the tax base in rural America continues to erode because of the recession there, the ability of rural state and local governments to continue subsidization of indigent care is becoming sharply limited. Decreases in or withdrawal of support from county or city governments have severely increased the unsponsored care burdens of many hospitals and put additional strain on public hospitals.

In the past hospitals and physicians financed the cost of unsponsored care through a system of higher charges to other payers, including employers, insurance companies, and individuals who paid their own bills. However, Medicare and Medicaid provide no allowance for the costs of indigent care. And, increasingly other third-party payers--insurance companies, businesses, and health care coalitions--are able to negotiate contracts for health care services under a variety of payment schedules that do not include the costs of care for the indigent. In addition, use of precertification review and other health care cost containment efforts by third-party payers, as well as

changes in the practice of medicine, have shifted the locus of care from the inpatient to the outpatient setting. Many rural residents may not have insurance coverage for inpatient hospital care much less outpatient care and are not able to pay for the cost of health or medical care themselves. The combined effect of these factors as well as competition in the health care sector, a decrease in federal revenue-sharing monies, and the recession in rural America are making it even more difficult for rural hospitals to cover uncompensated care costs and ultimately unsponsored care costs.

BACKGROUND ON JEFFERSON COUNTY

Jefferson County Hospital, the facility I administer, exemplifies the impact of these problems on the nation's rural hospitals.

Demographic and Geographic Information

Jefferson County is located in southwestern Mississippi and is bordered on the west by the Mississippi River. Its county seat and only incorporated municipality, Fayette, has a population of slightly over 2,000. Fayette is located 25 miles north of Natchez; 45 miles south of Vicksburg; 80 miles west of Jackson, the capital of Mississippi; and 150 miles north of New Orleans, Louisiana.

The population in Jefferson County is steadily declining. In 1980, the population was 9,181, with 82 percent of the population black and 18 percent white. Population projections for 1988 are that the total population in Jefferson County will be 8,563, a 6.7 percent decrease from the 1980 population, with 88 percent of the population black and 12 percent white. The county's 1981 per capita personal income was $6,612, over $750 below the state average. Almost 28 percent of Jefferson County's total personal income comes from transfer payments, primarily welfare payments; approximately 41 percent of the county's residents have incomes below the federal poverty level; and the county's unemployment rate for 1986 was over 20 percent. (It should be noted that, according to the 1980 U.S. Census, of the 50 states, Mississippi ranked as the state with the lowest personal income per capita and the highest number of persons below the poverty level.) If the present downturn in population continues, the economic future of Jefferson County is in jeopardy. Already many residents who have labor skills are moving to other areas where they can find employment. Those who remain will be chiefly the very young, very old, and unskilled. And, it can be expected that the numbers of indigent will increase.

Jefferson County's chief industries are timber and agriculture. The county has substantial timber resources with 258,000 acres of commercial forest land. The principal agricultural crop is soybeans, and cattle and poultry are also major sources of farm income. The county's largest employers include automotive wiring and assembling plants and a furniture parts plant, employing a total of approximately 260 people, and a log and pulpwood company and a sunbonnet company employing a total of 30 people. However, employment at these companies is cyclical, depending on the demand for these companies' products. Jefferson County Hospital, which employs between 65 and 70 people, is also one of the county's largest employers, and has over the years been a stable source of employment for county residents.

Health Care Services

Jefferson County Hospital, which was built in 1965, is the only hospital in the county. The hospital is located between several regional medical centers. These include the University of Mississippi Medical Center and Hinds General Hospital, which are 85 miles away in Jackson; Mercy Regional Medical Center, Vicksburg Medical Center, and Kuhn Memorial State Hospital, all in Vicksburg 65 miles away; and Jefferson Davis Memorial Hospital in Natchez, 25 miles away.

The hospital provides a limited range of general medical services and only performs minor surgeries. The primary illnesses treated include heart

disease, hypertension, and chronic obstructive pulmonary disease. After considerable review, the hospital has determined that it could not be a full service hospital, because it is not doing any major surgery, nor does it have an obstetrics department. It does, however, provide limited obstetrical services as needed; in 1986, 28 babies were delivered. The majority of deliveries are cared for in Natchez.

The hospital also operates an emergency department and an ambulance service, and must be able to triage and stabilize emergency cases as they arise. The ability to do this requires a certain amount of technology--equipment and technical expertise--as well as capital to sustain a viable operation.

In addition, we implemented a swing-bed program in 1985 because the nearest nursing home is 25 miles to the south and others are 65 miles to the east or north. This program enables us to shift the care in some of our hospital beds from short-term services for acutely ill patients to post-acute extended care services for our patients and back again depending upon patient and community need. Because of the lack of nursing home beds in the community, the swing-bed program helps us meet the post-acute care needs of some of Jefferson County's residents. These patients can remain in the community rather than being transferred to distant communities and facilities for needed care.

We also have established a networking arrangement with Hinds General Hospital for educational and some professional and technical assistance. For example, we are able to send employees such as Registered Nurses for educational and technical assistance training to this institution. To provide additional sources of revenue, as well as a service to the community, the hospital operates the only restaurant in town. However, initiatives to develop additional revenue sources are curtailed by restrictions from the county government as well as the lack of capital. There are absolutely no excess funds available in the community either at the governmental or the personal level.

Other health care facilities in Jefferson County include an outpatient clinic operated by the Jefferson County Health Department. For a minimal fee, this clinic provides medical care and medication for family planning as well as maternal and infant care. The clinic is operated on a limited basis by rotating health department physicians. Jefferson Comprehensive Health Center, Inc. also provides medical and dental services on an outpatient basis. Southwest Mississippi Regional Mental Health-Mental Retardation Commission has been serving Jefferson County since 1974, and Southwest Mississippi Emergency Medical Services coordinates emergency medical services communications and provides some in-service training for emergency medical technicians in an eight-county area. There are also two pharmacies, one dentist in private practice, two family practice physicians in private practice, and one family practice physician and one internist employed at the comprehensive health center.

Patient care data and statistics from our 30-bed hospital indicate that in 1986 the hospital:

- handled 1,600 outpatient visits and 2,900 emergency room visits;
- had an inpatient occupancy rate of 64.6 percent, with an average daily census of 19.4;
- provided 7,004 days of care (nearly 17 percent were for Medicaid recipients; 39.7 percent were for Medicare beneficiaries; 6.2 percent were for swing-bed patients; and 36.6 were for private, self-pay patients);
- had an average length of stay (ALOS) of 5.2 days (the ALOS for Medicare patients was 6.5 days; for Medicaid patients, 3.5 days; for private, self-pay patients, 4.8 days; and for swing-bed patients 41 days). [To control their medical assistance expenditures, some states have placed ceilings on the number of days medical assistance patients may remain in the hospital. Currently, the Mississippi Medicaid program assigns a length-of-stay limit to inpatient hospital acute care for Medicaid patients.]

FINANCIAL PRESSURES ON THE HOSPITAL

Jefferson County Hospital, like many public hospitals around the country, has a serious financial problem. Our Fiscal Year 1986 budget was $2.156 million. During the period from 1981 to 1986, the hospital's unsponsored care costs increased over 200 percent. For FY 1986, the hospital's uncompensated care costs were $209,447.53. We received a direct tax subsidy from the county government of $40,503.28, leaving unsponsored care costs of $168,944.25.

For the past two years, the hospital has experienced net patient deficits. In FY 1985, it had a 24-percent net patient deficit and in FY 1986, a 20-percent net patient deficit. To sustain operations, these deficits are being funded partially by depreciation monies and partially by decreases in the hospital's unrestricted funds or working capital. This situation cannot possibly continue. Tax appropriations from the county help, but they are not in the range of 7 percent of total expenses, which is the national average for public institutions. Last year we received $40,500 from the county, or 1.9 percent of total expenses; this year we will receive only $30,000, a decrease of $10,500 because of the reduction in federal revenue-sharing funds.

The hospital is currently receiving payment under the Medicare prospective payment system's (PPS) disproportionate-share provision. Hospitals which have a disproportionate-share percentage greater than 45 percent are eligible to receive this payment. When we applied to Medicare to determine our eligibility for a disproportionate-share payment, our Medicare fiscal intermediary calculated that Jefferson County Hospital actually provided almost twice as much care.

While the added monies from the disproportionate-share provision have helped, they are not enough to offset the tremendous increase in uncompensated care that our hospital faces. The average income in rural areas is historically much lower than that in urban areas, therefore suggesting a larger proportion of unpaid bills and higher unemployment rates. The costs associated with uncompensated care have not been factored into the present disproportionate-share adjustment. This is of vital concern to small, rural hospitals because there are varying criteria for Medicaid eligibility in the 50 states.

The present Medicaid eligibility criteria discriminate against the typical family configuration of rural areas where two-parent families predominate. In addition, the Medicaid programs in many rural states like Mississippi do not provide as much coverage as those in more urban states. Also, many county residents have been or are self-employed farmers, fishermen, or pulpwood sawyers and haulers who lack primary health insurance coverage. Because many people in Jefferson County have not met the work eligibility criterion for Medicare (to work a designated number of quarters), they do not qualify for Medicare Part A coverage.

More importantly for rural America, there is a social stigma with respect to applying for Medicaid in many rural areas versus the anonymity of being poor and applying for Medicaid when one lives in densely populated urban and metropolitan areas. The economic problems in rural America seem to be escalating more quickly than in other areas of the country, with a concomitant effect on rural hospitals. Many of the rural elderly and poor are not able to travel any distance to obtain medical care because access to transportation is limited. And, the increasing cost of providing care for the indigent has a tremendous financial impact on rural institutions, especially those in isolated or economically depressed areas.

With the advent of the Medicare PPS, cost containment efforts of other third-party payers, increased competition, and changes in the practice of medicine, Jefferson County Hospital does not have the financial capacity to meet the increase in the cost of charity care and bad debts as it has in the

past. We are not in the business of making money, but we have to have money to continue to be able to provide health care services to county residents. The reduction in reimbursement from Medicare and Medicaid has caused a decrease in the hospital's revenue and has had a subsequent ripple effect on the hospital and the community. We have had to reduce staff, causing further reduction in the economy of an already economically depressed community, resulting in erosion in the community's tax base, which then is reflected in the amount of tax appropriation the hospital receives. This is a vicious cycle, and it is happening in many areas of rural America.

FUTURE OUTLOOK FOR THE HOSPITAL

The future of Jefferson County Hospital is threatened both by its mission and by the increasing financial stress the hospital is facing. The hospital exists for the purpose of undertaking any function, activity, or service which will promote the health--physical, mental, and social well-being--of all Jefferson County residents, and such services are to include acute inpatient care at the primary level, emergency services, and long-term care services. The combined effects of national, state, and local governments' efforts to control health care costs; the development of a competitive health care environment; changes in the practice of medicine, including an increase in the use of medical technology; and the rise in the number of indigent have significantly eroded the ability of Jefferson County Hospital to continue to exist. If these trends continue, and if Jefferson County Hospital does not receive additional financial support or additional revenue sources to cover its very large unsponsored care costs, it is in danger of closing in the next three to five years.

CONCLUSION

The greatest challenge for us today is how to address the problem of providing health care for the indigent. The traditional methods of financing care for the uninsured are being stressed beyond their capacity. There is no question that hospitals providing substantial amounts of care to the poor are less able to survive and maintain access to health care for the poor in our society. Unless new sources and methods of financing care for the indigent can be found, many public hospitals may be forced to close, jeopardizing the ability of many people to obtain needed inpatient medical care.

Finding a solution is not the responsibility of any one group or segment of society, nor is there "one best way" of addressing the issue. A lasting solution will require efforts by both the private and public sectors. The private sector can take action to make affordable private insurance more available and reduce the number of persons without health insurance. Although expanding the availability of private insurance is important, a significant number of individuals will always be uninsured and will need direct public assistance. A stable source of funding that broadly and equitably distributes the cost of care for the medically indigent among all Americans should be identified and put in place. It is going to take a while to find appropriate solutions; our hospital needs help until that happens.

Thank you for giving me the opportunity to present my views on this difficult and critical issue.

Chairman STARK. Thank you very much, Ms. Brown.

According to a study done by the Robert Wood Foundation not so long ago there were probably only about a million people in the United States who could not get medical care because they didn't have enough money. There were another 4 or 5 million who didn't get medical care because they thought they couldn't afford it.

If these figures are correct, it presumes that the system whether it's the Veterans' Administration, the military, or other forms of delivery, is providing care to everybody else except perhaps 5 or 6 million people who for real or imaginary reasons really can't pay for it.

If that assumption is correct, it seems to me that someone in the country one way or another is paying for medical care. We're all paying. I may be paying in Oakland through higher real estate taxes, or I may be paying Aetna a higher premium because you are billing me or my dependents a higher room rate. Somehow, somebody is paying it.

I've heard each of you testify this morning that it's unfair that you, the hospitals pay. One of the problems that we face is that we have very, very lousy numbers. Part of that is the hospital's reluctance to release data which they figure may put them at a competitive disadvantage. Partly it's because we don't have a standard system of accounts and reporting. What boggles my mind is that there are fewer hospitals in the United States than there are parts in a B–52. We manage to keep track of the B–52 parts, but nobody has a computer that keeps track of all the hospital data if we would extract it from you.

I mean, beyond Medicare, we'd have you on your private data as well as your Federal data. We would then be able to at least quantify a problem and sort it out.

Then it further seems to me that we've heard testimony here that some of you may dispute, that there was a higher percentage of surplus or profit, if you want to call it that, paid through Medicare than we thought we were paying. In other words, instead of the 3 percent margins of years past, you are getting 12 percent. I presume that in some of your cases this was evened up by uncompensated care.

Ms. Brown has a unique problem. While I recognize Mississippi's impoverished status, it still always comes back to us that your qualification for Medicaid is probably around $2,000—not a whole lot higher than that for a family of four. I guess that's about where you are to qualify.

In California it's $10,400 at the other end of the scale. So it might be easy for me to say for a relatively prosperous State just raise the Medicaid level and take those folks in. Then you'll collect for them under Medicaid. It's easy for me to say now that it was a dumb thing to listen to the call in 1984 to separate Medicaid from Medicare so that we would give the States more flexibility.

I don't know of any States, that raise what they're paying under Medicaid once they were given the ability to lower it.

All this leads me to think that the real solution would be to give the person a piece of plastic or whatever that we provide at the Federal level. It doesn't matter how we pay for it—maybe just argue whether we take it out of the income tax, or whether we

take it out of the private head tax on all employed people. However we collect it, wouldn't we be better off finding a way to put the money for your bill in the patient's hands rather than trying to adjust everything, a little bit for teaching and a little bit for disproportionate share? I'm not sure what that is, but we adjust and fuss, and I've never seen a bill in the 3 years I've been on the subcommittee that's made all the hospitals happy.

So my question is would you prefer that we keep doing this kind of aggregate adjusting, or should we work toward trying to get the money into the hands of the people who walk in your doors?

Dr. MONGAN. Mr. Chairman, could I respond to three points you made in those remarks.

First, let me address the Johnson Foundation study.

Second, let me address the Medicare profits.

And third, let me address the optimum way of dealing with this problem.

With respect to the Johnson Foundation study, the problem with that study is that it masks the pain, it masks the problem, and it masks it in two ways.

Yes, indeed, it is true that for people who get dramatically ill, anybody who falls down, breaks their arm and the bone is sticking out in Kansas City, will get taken to the hospital and treated. But if you let the public facilities deteriorate, and I'm afraid as witnessed by my testimony, we're beginning to see that, you're going to see some quality of care problems behind that study that aren't shown.

Chairman STARK. We don't see it. We don't suffer with the person.

Dr. MONGAN. That's correct.

The second problem that's masked is there's a lot of people who delay care, and we know that again. We see people whose condition is further advanced. We see tumors that are further along than they ought to be. We see hypertension that is further along than it ought to be. We see women too late in their prenatal course.

So there's a lot of masked delay and deferral paying behind those numbers. So while I would not quibble with the numbers in their starkest sense, they mask a lot of problems.

Chairman STARK. Actually, isn't that just increasing the cost? What I'm saying is, if a women had had early prenatal care, it would cost less than if you see her in the seventh month. By then don't we just increase the cost and probaby have a child problem in addition.

So I hate to turn this into numbers, but what you're really saying is the same thing. You're just kicking up the costs, and somebody pays.

Dr. MONGAN. That's right. I just don't want people to leave the room thinking we've got a 1 million person or a 3 million person problem. We've got a 30 million person problem because the others are masted behind these tip of the iceberg numbers.

Second, with respect to medicare profits, yes, we're profiting under Medicare at about the same rate that other hospitals are profiting under Medicare, but for every dollar of profit, we have slightly more than a dollar's loss in the other federally sponsored program, Medicaid. We're in fact in the hole when we come out of

the federally sponsored programs before we even start to deal with our indigent care burden.

And I think there's two other points that should be made about that.

First, as you indicated, this is a direct consequence of a federal action to let the States sever their payment rate from any relation with cost. I think that was a mistake. And it should be undone.

Second, this problem impacts most severely on hospitals like ours which serve a disproportionate number of Medicaid patients. They're the ones who feel that pain.

And I think a possible solution to this problem would be for you all to work with your colleagues on the other committee, and, in fact, consider an amendment to mandate that States pay disproportionate share hospitals under Medicaid for all the days of service they provide at cost.

Chairman STARK. That sure would make Governor Dukmajean do the right thing, wouldn't it?

Dr. MONGAN. Absolutely. It certainly would.

Chairman STARK. I'm sure the rest of you don't bear the burden I do in California. You all have good Governors.

Dr. MONGAN. You could put a limit on that kind of payment to let it increase just by the amount ProPAC allows for DRG so it wouldn't be a blank check, but you should force the States back to paying adequately.

My last comment has to do with your point about the proper way to deal with this problem.

Not a shadow of a doubt in my mind that the best way to deal with the problem that we have is an appropriately constructed moderate program of national health insurance for this country. But nobody is talking about national health insurance these days, and until that cycle swings back, our problem is we need assistance to keep going until we have the right answers.

Chairman STARK. We're really talking about this on this committee. It's called a camel, and we're just trying to get the head in the tent right now.

Dr. MONGAN. That's true, and let's get the head under there, but while we're waiting to get the body under let's do something to keep these facilities going so that we'll be here and be able to provide that care at a point when this country does what it ought to do. But I agree with you wholeheartedly.

Mr. CONNORS. Could I add to Jim's reaction? I—with regard to the disproportionate share, both public and private providers, I think in the short run some attention to that is absolutely essential. We have one disporportionate share hospital by the formula adopted in our organization. I would share as an aside that we had to join some other private providers to sue the Government, the department, to carry out the congressional mandate.

That——

Chairman STARK. I hope you won.

Mr. CONNORS. We did.

The disproportionate share hospital gets around $400,000 to $500,000 a year, as I recall. That individual institution is sitting in the middle of Detroit, and our overall loss when it's all said and done, including that, is $5 million a year. So it's hardly keeping

that afloat. That organization couldn't stay afloat if it weren't part of our system.

With regard to the solutions, Mr. Chairman, and members of the committee, I therefore think that some short run disproportionate share attention is required.

In the long run, it would be our belief that the purchasing power has to be placed through insurance in the hands of the persons, both Medicare and Medicaid, and that those persons need to be treated in the mainstream quality institutions under conditions that meet all the tests of the rest of the population.

That I think is going to require a universal health insurance that's built both on private insurance and its continuation for employees and their families with standards, and a public insurance scheme that covers both Medicare and Medicaid, and this $35 million population that's now the scope of the problem of the uninsured.

Mr. ALLISON. Mr. Chairman, I'd just like to add to what's been said, and some specific examples.

As in Texas when we implemented the indigent care package, one of those provisions was for the Maternal and Infant Health Improvement Act, which was trying to identify in a prenatal setting the high risk mother, the teenage pregnancy, and try to deal with it on a prenatal basis because study has indicated that if you can find those people, identify them, and take care of them in a prenatal setting, it costs much less. For every dollar spent on prenatal care, you can save $3 by keeping the infant out of Neonatal Intensive Care Unit.

Chairman STARK. Do you have any results of the cost basis yet?

Mr. ALLISON. Yes, I have an addendum, to my testimony as to the results of these various indigent care packages.

Chairman STARK. Did you select the recipients of the prenatal care by geographic selection, by income screening, or by some other criteria?

Mr. ALLISON. It's done both ways. People were able to apply for the grants through that program of State funds that were made available so that they could begin to go out into the different regions and identify the recipients who needed assistance.

Chairman STARK. Do you think Texas is going to make a case if this was a cost savings to them?

Mr. ALLISON. Cost savings, yes. Spend a dollar to save $3.

Chairman STARK. I have a district with 19 to 20 in a 1,000 infant mortality rate. I've always felt that, that we'd save money in the long run if we would provide prenatal care.

I'd like more details.

Mr. ALLISON. And it's included. There's an update on the indigent care legislation, which is in my testimony as an addendum.

The other point I would make is, of course, that the indigent populations, as Dr. Mongan said, use the healthcare facilities inappropriately. Then wait for care. We're the neonatal intensive care unit for the region, and the patients often will wait until the eighth and ninth month of pregnancy before ever seeking medical care. They wait to come to the trauma center when their illness is more acute and often very costly.

The other point about the closures of hospitals in Texas, and unless you've driven through west Texas you cannot appreciate perhaps the distances that we're talking about between communities, and when we have hospitals closing, and more, particularly in the Panhandle area in west Texas, threatening closure because of financial difficulty, you're talking about people in communities being 100 miles away from the nearest facility. And we're talking about access to care at that point. And there is concern, and these rural hospitals do need assistance, they do need help. Because what we want to be able to provide is the tertiary service. We need those hospitals out in those communities to survive so that they can meet the needs on a primary level, and then we're able to channel our resources into the tertiary.

Ms. BROWN. With the declining factory businesses, the poor farmers who are facing foreclosure, rural areas are having a difficult time. In Jefferson County we had the good fortune of having Charles Evers as our mayor, and he did bring in some industry, but that is not enough to support our community, where 28 percent of our personal income is from transfer payments, primarily welfare payments, and 41 percent of our county residents have incomes below the federal poverty level.

Chairman STARK. Do you have a sales tax in Mississippi?

Ms. BROWN. Yes, 6 percent.

Chairman STARK. How about a timber severance tax?

Ms. BROWN. We do get some money from timber. But not enough.

Chairman STARK. Mr. Chandler?

Mr. CHANDLER. Thank you, Mr. Chairman.

I know that on the statistical side of health insurance in the private marketplace, it's becoming evident that for small, new, and nonunion employers, those three categories, there is less and less tendency for the whole range of benefits, including health insurance, to be provided.

You mentioned, Ms. Brown, that some people who end up being uncompensated patients are actually employed.

I'd appreciate it if you all could expand on that fact because I think there's a growing concern—there certainly is in my mind—that unfortunately the voluntary system of provision of benefits, including health benefits, isn't working very well within the category of employers that I just mentioned.

Are those people showing up in your hospitals seeking and receiving care and then becoming uncompensated patients?

Ms. BROWN. In our case specifically, we have a large timber industry. The pulp wood hauler does not make enough hardly to support his family, much less to buy health care.

The small farmer——

Mr. CHANDLER. I'm sorry. Are those primarily jip hoe type operators, or maybe that isn't the term you all use? That's the guy that's on his own.

Ms. BROWN. Okay. He's on his own.

Our county is 80 percent black now, and it's—the projected figure is going to be 11 percent Caucasian, and 89 percent black by 1988. We're finding a mass exodus from our county because we cannot provide employment, adequate schooling, and along with

this exodus comes an erosion of the tax base, and the ability to pay for their health care.

Dr. MONGAN. Mr. Chandler, our situation really is what you've heard here in the urban area. When we look and do snapshots of our patient population, those who don't have coverage, time and time again we find the same thing, the vast majority of those people are employed, but they're employed at jobs like attendants at car washes, or waitresses in restaurants, and those jobs simply don't carry health insurance coverage.

Now, what can you all do about that? It's a very difficult problem for you.

Before I went out to work with this problem in the real world, I used to work with it back here in your town, and we put together all sorts of health insurance schemes, and one of them was trying to maybe mandate that the employers provide coverage. But then you run into all sorts of problems about adding to unemployment, adding to inflation, and the incentives for part-time work. There's a whole bunch of problems.

I'm kind of convinced in my own mind that ultimately we've only got one direct solution, and that's to use the most appropriate broadest base tax, which is the payroll tax, and do it like you do medicare.

But I think we're a long way from that at the present time, and, again, I get back to my plea that we do something to assist our institution while we await the future.

But I agree, a big part of the problems are the employee population. We've got two choices, you either try and give incentives, or move toward mandating coverage for that population, or else you have to do something on the public side, and in the interim please help us while you're dealing with it.

Mr. CHANDLER. From your experience you're suggesting that probably compensation as a total wouldn't change all that much for these individuals. They're either going to lay off workers, or they're going to simply include the health benefit as part of the compensation in a mandated system.

Dr. MONGAN. Those were some of the problems we looked at when that was discussed last time, I don't want to sound like I'm against that. If I were king I'd probably try and move toward that. But it's not free. There's no free lunch. It does lead to problems of unemployment, inflation, et cetera. So it's not free, but there is some merit to moving further than we have towards mandating perhaps at least some catastrophic coverage, or something of that sort, to get us in a better position than where we are now.

Mr. CONNORS. Two things, Mr. Chandler, that I think characterize the employer behavior in the part of the world that I serve, one is that more employers are really going to self-insurance in their health benefits, and rather than purchasing any indemnity true insurance coverage for that, they're managing their own risks internally.

And understandably, that has led those employees to focus on that element of cost in producing their product, and whereas in the past the amount they paid for insurance always contained an element that was when paid able to be rendered to charity care.

They're now saying from their perspective that that's not their problem, that's the Government's problem, or someone else, so they are squeezing out of the payment mechanism, and the cost definition of what they're covering, care for anybody except their own employees.

And that has just reduced our opportunity to cost shift that has been a mechanism of paying for charity care in the past.

Mr. CHANDLER. If I could just follow up on that. I'm sorry to interrupt.

But don't you think they've also tried to escape some of the mandated coverages—you're Michigan, right?

Mr. CONNORS. Michigan, Iowa.

Mr. CHANDLER. I know that's been the case at home that where the State mandates some particular coverage, there is an exemption for self-insured employers, which allows them to cover whatever they want to. I think they're taking advantage of that too, which isn't an issue.

Mr. CONNORS. Yeah, there may be some of that. I don't think that's the predominant motivation in our part of the country. It is the actual cost of the health insurance benefit as contrasted to being categorized as not being covered, they do it themselves.

Mr. CHANDLER. But these are the large employers.

Mr. CONNORS. But in where we serve, I think the habits of large employers carry over to the others.

I'd say the second major behavior is that employers understandably want predictable costs for the future as much as they want a change of responsibility. And that's why the capitated system in the long run can be so appealing, I believe, to both private employers, as well as government, because it is predictable in advance with responsible providers of care, then being in a covenant, or position to render the care they said they would.

Chairman STARK. Mr. Coyne?

Mr. COYNE. Thank you, Mr. Chairman.

Dr. Mongan, you indicated that at Truman Medical Center over the past 5 years, there's been a 28-percent increase in admissions while other hospitals in your areas have experienced a 24-percent decline of admissions.

I'd be interested to know what you feel some of the reasons for that are.

Dr. MONGAN. Well, I think the reasons are twofold. With respect to the decline, we see nationally a dropoff in admissions. Now, I don't have the exact numbers nationally, but I think they're not too far out of line with what we see in Kansas City with the advent of DRG and other programs, you see a national decline.

The real issue is why are we different, why do we go counter to the trends, and the answer to that clearly in my mind is we have more people without health insurance coverage in Kansas City than we did 5 years ago. We recently completed a statewide study which documented that fact.

So we have more people without coverage. They're coming to us either self-referred, or referred by physicians in the community.

What we're not seeing in our community—and I'm very pleased we haven't—we've not seen the kind of dumping I've read about in some other areas of the country. In fairness, I think if anything, we

see reverse dumping. I don't have patients transferred to my facility from other hospitals, and frankly, I'm transferring indigent patients from my hospital to others on those two or three nights a week when we're full, and for some specialty services we don't provide.

So I think the indigent care provided both at our facility and at the other hospitals in the area, has increased over the past 5 years. The real problem is more people without coverage, a greater burden on us.

Mr. COYNE. You bring up a good point. I was going to ask the other panelists, do you have any evidence that there is dumping in your areas?

Mr. ALLISON. I'd like to respond to that if I could, sir.

I think there's been a lot of discussion from a national level what Texas did when we enacted our transfer bill, and it was presented more or less as an antidumping bill, and there were some concerns and questions about transferring patients for economic reasons only rather than medical necessity, and we did get legislation that prevented that from occurring.

And in some areas there were more problems than others. In our area, the Panhandle, for example, since we operate an emergency medical system and a regional trauma center, we've had good cooperation with our outlying hospitals and we are now doing some things that are very positive in being able once the patients come in, and are stabilized, then they can be sent back to the outlying community that the patient was transferred from.

We are beginning to see evidence where in some areas dumping has occurred, but there is a mechanism to deal with it. We also receive some assistance through the recently federally enacted legislation program on dumping.

I think this is something that can continue to be worked out in the local areas. We're seeing some discussion now and concern about reverse dumping where you have a patient that needs to be transferred, it is a medical necessity, but in some part of the state there are not public hospitals, or voluntary hospitals willing to take those who do not pay, and so they're not receiving them. And I think this may raise its head as a problem that we're going to have to deal with, and we're going back to the access to care situation.

And I would just like to say on the occupancy deal, our own association members have seen the stabilization of occupancy rates and many have increased because we're identifying the shifting of the uncompensated patient. Many are self-referring, or seeking help because they have no other source of care. So it's very real.

Mr. COYNE. Anyone else care to comment?

Mr. CONNORS. I'd like to comment. We don't believe that there is dumping of patients for economic reasons to those of us who are willing to them in the areas that we serve. The most likely place where one might think that would be happening would be the metropolitan area of Detroit because our other areas there are no alternatives anyway, in most cases.

That dumping is not taking place to the best of our knowledge in the metropolitan Detroit. What is happening though is what Jim says, is that a lot of deferred care on the part of those persons who

will come directly to our emergency room, and for example, our two innercity hospitals, 60 percent of our admissions come through the emergency room and have had no prior medical care for that incident of care. That's why we're trying to create these, and have created, these primary care centers, to try to put the continuous care in an ambulatory setting where they're needed.

We do not in our own system turn away any patient who needs care. There are a few patients that we do not have the specialty services backup, and we have arrangements with other hospitals as the patient gets stabilized to transfer.

But the only reason that we transfer has to do with our capacity to deal with that patient medically, not economically.

Mr. COYNE. Thank you very much.

Chairman Stark. Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman.

I think this is an especially important hearing. We've been focusing under your leadership, and Mr. Gradison's on the issue of catastrophic illness.

Today we're talking about the degree to which care is lacking on a day-to-day basis, and for how many Americans.

At least two questions occur to me, therefore, how deep the crisis is, and what the answer is.

Some of the data given today, I think, are striking. I found striking Dr. Mongan's testimony, that was referred to by the gentleman from Pennsylvania, about the increase in admissions, and also the growing number of people without health insurance coverage. You know, in 1982 and 1983 a number of us tried to find out what was happening to people who lost their health insurance, and how many there were, and we didn't know how many people in this country were losing it, and what was happening to them.

Also, I found striking Mr. Allison's testimony about Texas. In your part of Texas, among your members, if I read this right, in 1986, you had almost $900 million in uncontrolled revenues out of the total revenues of $1.8 billion.

Mr. Connors, and Mr. Derezuinski, who is also here this morning, and I had a chance before the hearing to go over the figures, Mr. Chairman, and I think it's interesting for the Mercy Hospital a profit margin for medicare is 6 percent, isn't that right?

Mr. CONNORS. Yes.

Mr. LEVIN. I think that shows how we need to disaggregate the figures that we've been given according to urban, and rural, and the like, because not all hospitals have margins of 12 or 13 percent some have half of that.

Mr. Connors, you mentioned in your testimony that, on Medicaid, what you receive is 10 percent less than the cost. So it would appear with the added testimony from Mississippi, although we have a crisis of some real significance in this country, that maybe it's less visible than catastrophic problems, because it's kind of day-to-day. It's, in a sense, more incremental than traumatic, but maybe more dramatic because it adds up.

Let me ask you about the answer—the possible answers, not playing the devil's advocate, but I can hear the response of some.

For example, in Texas the response was for the State that of the close to $900 million in uncollected revenues, more than half of it was eventually picked up by city, county, and State tax dollars.

So, I think that raises the question, shouldn't Washington simply keep the heat on the city, the county, and the State.

And to you, Mr. Connors, I think I hear another response. If there's acknowledgement of the depth of the crisis, and shouldn't you look further to philanthropy. Isn't that really the answer, a combination of local governmental units and the private sector?

So if all of you would address that.

Mr. ALLISON. I'd like to respond, if I could.

To begin with, on the Federal Government's role in involving this, and where they should be, it was the Medicare, Medicaid, when they came into existence, promised access to care to a defined population. Medicare was to be the age 65 and over. Medicaid was to be predominantly to take care of the indigent under 65.

What has happened is that the statistics that I see, three-fourths of the Medicaid dollars are going to the poor Medicare patient, not leaving any funds to put at the State, the local level, to pay for those who cannot pay, and you're putting a disproportionate burden on the State and local governments. They are already over burdened and cannot continue.

You cut through the Federal programs. We heard Federal revenue sharing, that is causing cutbacks locally. And I don't think at this point that it's going to be fair for the Federal Government to abrogate its responsibilities since there are a large number of the Federal beneficiaries to the Medicare program that is having to be subsidized already by the local and the State governments because the full share isn't being carried by the Federal Government.

Mr. CONNORS. I think there are real limits as to the dependence on local tax base for this problem.

Take the State of Michigan, for example. As you know, Mr. Levin, the State of Michigan's Medicaid program has been a reasonably adequate program as contrasted to many States, and 15 percent of the State's budget is the Medicaid budget.

I doubt very seriously whether that could be practically increased by saying it's not enough because the, one, you're paying less than cost, which we can document, and the inpatient care is 10 percent less than cost, and we've got to make that 10 percent up some place.

And second, that there are those who are not eligible for Medicaid at all that are falling through the cracks, and they're being cared for, and in that payment for Medicaid there is no factor or recognition that those—that that care has to be rendered.

We manage some county hospitals in the State of Iowa. And the only practical source of revenue for that is the modest help in capital dollars when the plant needs major replacement. There is no mechanism for appropriation dollars to subsidize the inadequately financed care.

So I just don't think it is—perhaps is seductively political to some to say it is a local tax base responsibility, but practically where we serve it's simply not achievable. And, thus, I think it is, and I continue to believe that for a long time. It's ultimately the responsibility of the Federal Government to see to it, along with

the private sector, that citizens get the care they need. And that does require Federal involvement in the very nature of the State Medicaid programs, the eligibility limits, the services that must be rendered, and the way together it's going to be financed. And so I just don't think it's a practical way.

With respect to philanthropy, people who give money, both corporations and individuals, and we have about 12,000 people who give us a little money each year to a tune of about $5 million a year, so it's a lot of small gifts, they are not willing or anxious to give money if they feel that it's to subsidize care for what government was responsible to pay. They are able and willing to give money when it has a feature to it that provides a specific service to all patients, when it, perhaps, helps with a capital expenditure for a refurbished building, or a new outpatient setting, or a capital equipment. But we've been unsuccessful to go to organizations and individuals and say, oh, by the way, Medicaid pays us less—10 percent less than cost, and, therefore, won't you give us some money to finance that underfinanced care. That's not an appealing reason for philanthropy.

Dr. MONGAN. I would just very quickly second everything Ed had to say. I think the only answer to this problem is for everybody to participate, every level of government, and philanthropy. Philanthropy is not a major answer simply because this problem is much bigger than what philanthropy can deal with alone.

Ultimately, you've got to look to local, State, and Federal Governments all cooperating. I think it is part of your job to make sure that the State and local governments keep their feet to the fire. I think appropriate payment requirements under Medicaid are appropriate for you all to consider. I think maintenance of effort provisions for local governments are appropriate for you all to consider. But ultimately to deal with this problem, I'm convinced all levels have to participate.

Chairman STARK. Thank you.

Mr. Moody.

Mr. MOODY. Mr. Allison, does your State have an income tax?

Mr. ALLISON. No State income tax.

Mr. MOODY. Well, my State has a very heavy income tax, of course, and we spend a lot of that on exactly what we're talking about today.

Why should we, Wisconsin, pay more Federal income tax to help you solve a problem that we're solving with our own State income tax?

We are attacking this problem. It's our problem. And we are trying to cover it that way.

It's a little funny. You have a Senator, Senator Gramm, who is giving us holy hell right now because we may not meet the budget deficit targets. He's castigating us, having a field day in Texas, saying every Member of Congress is trying to spend more, not cut back. Senator Gramm carried Houston handily, as did the President, who said the problems are best handled locally.

And you're asking us here today to, in fact, help bail you out. It just doesn't square. Unless you are now representing the views of your State, which I assume you are.

Mr. ALLISON. Yes, sir, I am.

Mr. MOODY. Because your State has elected people who have the opposite philosophy.

Mr. ALLISON. I think I'd like to respond in this fashion, that while we do not have the State income tax, other tax burdens are placed on the local government to care for the uncompensated, the indigent, and to pick up the amount of shortfall that we experience from the Medicare, Medicaid programs. Through hospital districts, we have local taxing ability. We have major hospital districts throughout the State of Texas, and if you refer to my testimony on page 4, it says "local, city, and county, and State tax support for TAPNH hospitals has increased over the 4 years examined. In 1983, the average hospital subsidy was $28.6 million. In 1986, the figure rose to $36.68 million."

So there is a large amount that's being picked up by the local taxpayer that is not being borne by the State.

So there are the mechanisms that we have developed, and in passing the indigent care legislation, they created State funds while they were not necessarily Medicaid funds, but they created State funds for our indigent care programs.

We now have counties with responsibility that they had not had before. And so what we have done, Mr. Moody, is put it back on the local taxpayer, and the point is that we're getting to the point where you can't stretch the local taxpayer any further because a lot of those dollars are not just taking care of the local concerns, the local indigent. They are instead taking care of the federally insured patient who is not being covered on his cost.

Mr. MOODY. But they're still Texans. Maybe the way is—by and large—to elevate the burden to the statewide level, and apply a tax that will make up that difference instead of asking the Federal Government to do it.

I'm basically in your corner. I'm raising the question. I'm being the devil's advocate a little bit.

Mr. ALLISON. Sure. And what I say from the other side, had we not passed the indigent care legislation package 2 years ago, I couldn't probably come up here in good faith and say we're doing our part. We're doing our part much more than we ever have, and the local community that has a hospital district in Texas, is doing it by putting it on the local taxpayer. And I think what we're trying to say is we need, and I agree with Jim and Ed, cooperation on all levels of government. You've got to have local cooperation, you've got to have State cooperation, and Federal Government, all levels of government, as well as the private side working together.

What's happening is we're getting very fragmented and one particular entity is trying to underwrite for the others, and it's not going to be able to continue.

Mr. MOODY. The chairman mentioned a while ago that the Medicaid income cutoff of a family of four is $2,000 in Mississippi, is that right?

Ms. BROWN. I'm not sure what that is. It's lower than——

Mr. MOODY. It's less than $3,000 probably. In California it's $10,000 and Wisconsin it's quite high.

Ms. BROWN. In Jefferson County the per capita personal income is $6,612, which is $750 below State average.

Mr. MOODY. I'm sorry, I didn't mean to get off on that. As an opening comment, let me ask you, Ms. Brown, to respond to the same question I asked Mr. Allison regarding the philosophy of government, and how much your State is willing to tax itself to help Mississippians, and whether they are willing to change the Medicaid cutoffs to put in more State money?

Ms. BROWN. Well, we do have an income tax in Mississippi. Those of us in the hospital industry are lobbying actively in the State government to try to increase the Medicaid reimbursement.

Those of us hospitals who did not have that in 1982 or were very cost-efficient, were penalized because we have had a target rate based in 1982. You can hardly work on that in 1987.

I heard one of the gentlemen here talk about uncollected revenues. Our total patient revenue was $2,500,000. The uncollected amount which is the difference between Medicare, Medicaid, and what our revenue payments—and what our revenue was, and uncompensated care, was $733,000.

Now, what you are looking at when you break it down on a monthly bases is that we're operating 7 and 8 days out of every month for which we receive nothing, we cannot collect. You cannot survive when 25 percent of your revenue is not collectible.

Mr. MOODY. Thank you.

Ms. BROWN. Trying to maintain a staff in a rural area is really a problem because the technical people you send to town to go to a cardiac care course and the next thing you know they all want to be in a cardiac unit. Once they see the lights of Jackson, they don't want to come back.

Chairman STARK. How are you going to keep them down on the farm?

Ms. BROWN. Or the rural area of Marinette, WI, where I lived many years.

Chairman STARK. And that's why you don't make "yes" a four syllable word, is that it?

Ms. BROWN. I think in our area the venacular is "shoot yeah."

Mr. CONNORS. As long as we're identifying our Wisconsin heritages, I just want to say that I was privileged to try to steer your university hospital for almost a decade in the 1960's, and it was one of the highlights of my—I realize where you're coming from with regard to responsibility of your State to face this problem.

Mr. MOODY. You realize how much we tax ourselves to solve the problems you're talking about.

Chairman STARK. It's amazing how many great fearless intellectual leaders are born and raised in Wisconsin.

Mr. MOODY. The chairman himself.

Chairman STARK. I want to ask one other thing. I understand that most of the bad debt comes from bills under $2,000. It isn't largely the $100,000 complex case. Is it a fair assumption that it's a lot of small uncollected debts? By small, I mean, four figures rather than a lot of six figure uncollected debt that comprises the majority of your bad debt problems. Is that a fair assumption?

Mr. CONNORS. Under $10,000 not under $2,000.

Chairman STARK. Okay. Then is it also a fair assumption that the Stark-Gradison proposal, which will pick up out-of-pocket costs

for Medicare on part A over $520, will take a small step at least in solving some of your uncollected debt problem in that range?

Dr. MONGAN. I know I'm supposed to say yes.

Chairman STARK. I was sure hoping you will.

Dr. MONGAN. But I'm afraid the problem with some of these catastrophic proposals, as long as they're limited to Medicare is that Medicare will pick up our bad debt if you make the bonafide efforts to collect, et cetera.

Chairman STARK. We're not talking about bad debt though. Remember that now you've got all the first day twice, and the copayees, and all those things, which doesn't really hit a lot of your cases.

But I am suggesting that we're going to try and have Medicare pay everything save the first $520 under our bill. That should help a little bit. Not a lot.

Dr. MONGAN. That would be of some assistance, but again we do get a good deal of that back already under the——

Ms. BROWN. That would be of some assistance, but not much more. The majority of our people have Medicare and Medicaid.

Mr. CONNORS. It's an important start and will help in the incremental world of ours, and it will help.

Mr. ALLISON. One thing I'd like to say, Mr. Chairman, on that is in looking at the catastrophic illness issue in our hospital we get the sickest of the Medicare patient, and we get the poorest Medicare patient. We run about 19 to 20 percent Medicare while other hospitals are more in the 35 to 40 percent range.

What we find is, for example, we've got a couple of Medicare patients in our critical care units on the ventilator, they are going to be there for some time. Already their charges are up to nearly $275,000, the DRG is like at $30,000, and that adjustment alone can take away anybody's bottom line.

The other problem you have is once they get the patient to the point of transfer or dismissal, we find we have a hard time placing them in other facilities because they are the poor Medicare and nobody wants them.

Chairman STARK. Is that because it doesn't qualify as an outlier?

Mr. ALLISON. It qualifies as an outlier, but it's a very low reimbursement figure. So unless medicare through your proposed program, which I agree is a very good beginning, gives the money back to the providers for that large gap, you're still going to have major uncompensated care right off that can wipe out your bottom line.

Chairman STARK. I want to thank the panel. It's been interesting, and very informative. I apologize for being so lax in moving things along. But we'll have some time now for the panel No. 2.

Dr. Mary Henderson, senior research associate, Heller Graduate School of Brandeis University; Dr. Kerry Kilpatrick, director for the Center of Health Policy and Research at the University of Florida at Gainesville; and Dr. Lloyd Rucker, associate clinical professor of medicine, University of California at Irvine.

Again, I would repeat to this panel that your written testimony will appear in the record in its entirety, and if you'd like to expand on your testimony, or explain in more detail any particular part of it, you may proceed in whatever manner you're comfortable, in the order in which I recognized you.

Dr. Henderson?

STATEMENT OF MARY G. HENDERSON, PH.D., SENIOR RESEARCH ASSOCIATE, HEALTH POLICY CENTER, HELLER SCHOOL, BRANDEIS UNIVERSITY

Ms. HENDERSON. Mr. Chairman, and other members of the subcommittee, I'm Mary Henderson. I'm a senior research associate at the Health Policy Center at Heller School of Brandeis University, located in Waltham, MA.

I'm pleased to appear before you today to discuss the findings of our study which address the vital role that public urban hospitals play in providing health care to the poor and to the uninsured.

Our study of urban public hospitals was conducted jointly with the Citizens Budget Commission in New York City between 1984 and 1986. In this study we took two approaches.

First we used a broad brush approach to compare all hospitals, public and private, that were located in the largest 100 American cities. In this comparison we used data from the American Hospital Association and the Urban Institute.

Second, we studied intensively all the public hospitals located in four major cities, New York, Los Angeles, Memphis, and Tampa.

We focused on three areas of hospital performance, access to care to the medically indigent, quality of medical care, and efficiency of hospital operations.

We studied a number of issues. I will now summarize five of our major conclusions.

First, in America's large cities, which have a public hospital, more medical care is provided than in cities where there is no public hospital. In fact, under one measure that we used, we estimated that approximately 4,000 more admissions annually for the poor took place in cities with a public hospital compared to cities which did not have such a hospital.

Second, when the political system in the area is committed to the hospital that is serving as the provider of last resort, access to care for the medically indigent is greater.

We look for those specific factors which led some public hospital systems to decrease access to care for the poor in periods of fiscal restraint, while others maintained a high level of access.

New York City, Tampa, and Memphis all changed from being governed as a unit of local government to a quasi-autonomous or a quasi-private form of government fairly recently.

When subsidies were reduced, however, quite different outcomes were observed regarding access to care for the poor. In Memphis and in New York access was maintained or even increased. In contrast, in Tampa we found access to be cut back sharply.

We discovered that the degree of local governmental commitment and involvement in the public hospital helped to explain this difference.

In Tampa we found this commitment to be much weaker than what we observed in Memphis and in New York.

Third, acceptable or higher than average quality of medical care is delivered in urban public hospitals.

As you know, Mr. Chairman, quality of medical care is an extremely important issue, and one that's receiving a lot of attention recently. It is also an area that is very difficult to measure.

We used the Joint Commission on the Accreditation of Hospital Standards, commonly known as the JCAH standards. Against these criteria we generally found the public hospitals that we studied intensively to have acceptable quality of medical care.

Fourth, the perception of quality in public hospitals is closely tied to the hospital's physical structure. Therefore, local governmental commitment in maintaining and refurbishing the hospital affects the hospital's reputation for quality of medical care. Although by objective standards, the public hospital provides quality care, many times they're perceived as second rate institutions based on their physical structure.

However, improvements in the physical structure alone may not be sufficient to overcome the public's perception of these hospitals as second class. Other factors which we found to contribute to this perception of inferior quality, included a bias in favor of private institutions, as well as racial prejudice in some areas.

Fifth, we found that costs were higher in public hospitals, apparently because of a higher than average ratio of support staff. We measured efficiency as the cost for discharge. We found that public hospitals had higher unit costs than similar private hospitals.

Although our efficiency analysis did try to hold constant many factors, we were not able to adequately measure certain things such as patient severity of illness because the data were just not available to do so.

A clue to our higher costs was found when we looked at the staff-to-workload ratios in the four systems that we've studied intensively. We found that certain kinds of staff like registered nurses tended to be under-represented in the public hospitals, while others such as less skilled support staff were overrepresented; that is, their proportions were higher.

So we found that the staffing mix, and not necessarily higher average salaries, appear to be a cause of some of the higher costs in the public hospitals. And we thought this finding was interesting because it really highlighted some of the multiple social roles and political functions that urban public hospitals play: in many low income areas they're an important source of employment in these areas.

In summary, Mr. Chairman, we know that the urban public hospital is serving a vital role for our Nation's poor. We know some of the distinguishing characteristics of these hospitals. They service a disproportionately large percentage of Medicaid and uninsured patients. They provide acceptable quality medical care, but they are still perceived in many instances as second class institutions.

They have different staffing mixes, which may contribute to their higher costs. They are more likely to provide adequate care if they are supported politically and financially by State and local governments. And the volume of care provided to the medically indigent is not replaced totally by private hospitals in cities where there is no public hospital.

This concludes my formal remarks. Thank you very much.

[The statement of Ms. Henderson follows:]

STATEMENT

BY

MARY G. HENDERSON, Ph.D.
SENIOR RESEARCH ASSOCIATE
HEALTH POLICY CENTER
HELLER SCHOOL, BRANDEIS UNIVERSITY

Mr.Chairman and other Members of the Subcommittee, I am pleased to appear before you today to discuss the findings of our study which addressed the vital role that public, urban hospitals play in providing health care to the poor and uninsured.

I am Mary G. Henderson, a Senior Research Associate at the Health Policy Center of the Heller School, a graduate school for social policy training and research at Brandeis University.

FINDINGS

Our study focused on three areas of care to the medically indigent -- access to care, quality of medical care, and efficiency in hospital operations. We concluded:

Access

1) In America's large cities which have a public hospital, more medical care is provided to the medically indigent than in cities where there is no public hospital.

2) When the political system in the area is committed to a hospital serving as "the provider of last resort," access to care for the medically indigent is greater.

Quality of Medical Care

3) Acceptable, or higher than average, quality of medical care is delivered in urban public hospitals.

4) The perception of quality is closely tied to the hospital's physical structure; therefore, local government commitment in maintaining and refurbishing the hospital affects the hospital's reputation for quality of medical care.

Efficiency

5) Costs are higher in public institutions, apparently because of a higher than average ratio of support staff.

BACKGROUND

My testimony today is based on the study "Urban Public Hospitals: An Evaluation of Factors which Contribute to their Efficient Operation and Continued Viability", conducted jointly by Brandeis University and the Citizen's Budget Commission of New York City and funded by the Josiah Macy, Jr. Foundation between 1984 and 1986.

In this study, we took two approaches. First, we compared all hospitals, public and private, in the 100 largest cities in the country, according to a number of factors, such as cost per discharge and number of uncompensated care admissions. Second, we studied the public hospitals located in four major cities: New York, Los Angeles, Tampa and Memphis.

As you well know, Mr. Chairman, many state and local officials are concerned about care to the medically indigent. On their own initiative, they undertook a variety of strategies to alter hospital performance in three areas:

- o access to care by the medically indigent;
- o quality of medical care; and
- o efficiency in hospital operations.

Their strategies included:

1) changing the hospital's governing structure;
2) restructuring its financing arrangements;
3) altering its medical staffing arrangements; and
4) redirecting its market position.

We then studied what affect these strategies had, if any, and combined these findings with the results from our study of hospitals in the 100 largest cities.

ACCESS TO CARE

We know from anecdotal evidence and documented studies that the urban, public hospital plays a vital role in providing care to the medically indigent. For instance, in the 100 largest U.S.cities in 1982, urban, public hospitals accounted for only 5 percent of hospital beds but provided nearly 40 percent of all charity care, and 22 percent of Medicaid care.

While there is little debate about the major role these hospitals serve, some have questioned whether care to the medically indigent may not be better served through non-public community hospitals. These critics suggest that instead of using local government subsidies to support the public hospital, care for the medically indigent could be provided by the community hospital, either paid for directly by public funds or through a hidden tax on insured patients.

Our study, Mr. Chairman, did shed some light on whether or not community hospitals could fulfill this public responsibility effectively.

Comparison of Hospitals in the 100 Largest Cities

Using several sources of data[1], we compared access to care for the poor in cities with a public hospital to access in cities without a public hospital. We found that although private institutions devote more of their resources to care for the poor in cities with no public hospital, the total volume of care to this population is greater in cities with a public hospital.

As shown in Table 1, in cities without a public hospital, private hospitals devoted more of their resources to caring for the medically indigent than similar hospitals in cities with a public hospital (5.9% of hospital charges compared with 4.4%).

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[1] Data sources include the 1983 Annual Survey of Hospitals conducted by the American Hospital Association (AHA), a 1983 survey of hospitals conducted jointly by AHA and the Urban Institute and demographic and health-related data from the Area Resource File.

Table 1

Uncompensated Care as a Percent of Hospital Charges
By City Type and Hospital Ownership
100 Largest Cities,* 1982

Cities with Public Hospitals (70 hospitals)			Cities with No Public Public Hospital (29 hospitals)
All Hospitals	Public Hospitals	Private Hospitals	Private Hospitals
6.5%	19.8%	4.4%	5.9%

* Complete observations were not available for San Antonio.

Source: Thorpe, et.al., Improved Access to Care for the Uninsured Poor in Large Cities - Do Public Hospitals Make a Difference? Journal of Health Policy, Politics, and Law (forthcoming).

However, we found that although private hospitals make an additional effort to care for the poor in cities without a public hospital, the effort does not replace totally the care provided to the poor in cities with a public hospital. Our findings demonstrate this in three ways:

1) As shown in Table 1 above, in cities with a public hospital, 6.5% of hospital resources were devoted to caring for the poor compared with 5.9% of resources in cities with private hospitals only.

2) For those cities which had state and local public hospitals, there were a significantly higher number of uncompensated care (adjusted) admissions per poor person.[2] In these cities, approximately 32 admissions for each 100 poor people were provided. The comparable figure for cities with no public hospital was 24. In a typical U.S. city, this translates into approximately 4,000 more annual admissions for the poor if the city had a public hospital.

3) Using multiple regression, a further statistical refinement, we found that 48% more admissions were provided in cities with a public hospital. This particular statistical procedure allows us to measure the effects of the presence of a public hospital in a way that excludes other factors such as the city's location, and its racial composition. Thus, we can be reasonably sure that the greater volume of uncompensated care in cities with public hospitals was due to the presence of a public hospital alone.

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[2] The formula for adjusted admissions is:

$$\text{Adjusted Admissions} = (\text{Admissions}) \times \frac{\text{Total Revenue}}{\text{Inpatient Revenue}}$$

Once adjusted admissions were calculated, we converted uncompensated charges to equivalent uncompensated admissions by equating the following; solving for X generated our equivalent workload measure.

$$\frac{\text{Uncompensated Care Charges}}{X} = \frac{\text{Operating Charges}}{\text{Adjusted Admissions}}$$

Studies of Four Cities

In studying New York, Los Angeles, Tampa, and Memphis, we looked for those specific factors which led some public hospital systems to decrease access to care for the poor in times of fiscal restraint while others maintained high levels of access in those same periods.

New York City, Tampa, and Memphis provide examples of systems which all changed from being governed as a unit of local government to a semi-autonomous form of governance. However, they were strikingly different in the amount of care they delivered to the poor when public subsidies were reduced. For example:

o When local subsidies and Medicaid funding were cut for the Tampa public hospital system in the early 1980's, both inpatient and outpatient care to the poor were sharply curtailed.

o In contrast, the New York City public system maintained an adequate level of access to the poor despite a frozen budget and rapidly escalating health care costs in the 1975-1980 period.

o Similarly, in Memphis, even after the municipal hospital changed to not-for-profit status, the level of care provided to the poor did not change.

These contrasting outcomes under seemingly similar governing structures illustrate an important point. The access policies of public hospitals are strongly influenced by the degree of political commitment to serving the poor: legal structures and public subsidies alone do not appear to explain the level of access.

o In both New York City and Memphis, the hospital board remained closely allied with the local government, who, in turn, remained strongly committed to the hospital serving as a "provider of last resort."

o In Tampa, there was a clear message that the county government wanted to reduce its role in publicly-funded health care. Thus, it did not become closely involved with the hospital's decision to cut back on care to the poor.

o In Los Angeles, in the early 1980's, the County's willingness to assume the responsibility for care to the poor and additional State funding (caused by the transfer of the Medically Indigent Adult (MIA) program to the County level) led to the expansion of services for the poor in L.A. County facilities.

Taken together, the results of both our approaches have one common theme: more access to health care for the uninsured occurs when there is strong local governmental support (both in terms of financing and political interest) for the establishment and maintenance of hospitals designated as the "provider of last resort" in the community.

QUALITY OF MEDICAL CARE

As you know, Mr. Chairman, quality of medical care is an extremely important issue. It is also one that is difficult to measure. In our study, we used the criteria for quality of medical care established by the Joint Commission on the Accreditation of Hospitals (JCAH). In using these criteria, we

found the quality of medical care provided in the four public hospital systems to be acceptable. In each case, the facilities were granted JCAH accreditation and the deficiencies cited did not relate to clinical care standards. (These results are consistent with those of a separate, earlier study which found that New York City public hospitals had comparable or better quality care than similarly-sized New York City not-for-profit hospitals.)

Although by objective evidence, medical quality of care is at an acceptable standard, we found that public hospitals retained their reputation as "second class" institutions for other reasons. In the public's view, quality of care is often equated with the hospital's physical structure. When local governments fail to appropriate adequate funds for maintaining or refurbishing their public hospital, the hospital is not viewed as a desirable place to obtain care.

In New York City and Los Angeles, failure to invest capital led to deterioration of some facilities in the system. This was widely cited, t'en, as being responsible for their "poor quality" reputation. In contrast, the new governing bodies in Tampa and Memphis issued revenue bonds that were used to finance major new construction efforts. This new construction, in turn, markedly improved the public perception of these facilities.

It must be borne in mind, however, that improvements in the physical structure alone may not be sufficient to overcome public hospitals' "second class" status. In our report, we cited other factors that also contributed to the public's perception of inferior quality care at these hospitals, such as the bias in favor of private institutions as well as racial prejudice in some areas.

EFFICIENCY OF HOSPITAL OPERATIONS

In our study, we measured efficiency as the cost per discharge. Using multiple regression techniques, we found that public hospitals -- governed as either a unit of local government or as a semi-independent entity -- had higher unit costs than private hospitals. Although this analysis measured many factors, (including the types of illnesses treated and local area wage scales), other important factors could not be measured adequately, such as the social service needs of patients and the clinical severity of their illnesses. For example, other studies have found:

1) Patients with social problems were more expensive to treat in urban outpatient departments than similar patients without social problems; and

2) Public hospital patients were more severely ill than patients with similar diagnoses treated at private hospitals.

The studies of the four cities, noted above, provide an interesting clue about the inefficiency of the public hospitals. In each system we studied, we found higher staff-to-workload ratios for certain types of personnel than in similar private hospitals. For example, in public hospitals, registered nurses were found to be underrepresented, while less skilled, supporting staff were found in higher proportion. Thus, overstaffing of this type, not excessive wage levels, appeared to be a major cause of the higher than expected costs.

This particular finding highlights the multiple social roles and political functions of urban public hospitals: in low income areas they are an important source of employment.

CONCLUSION

In summary, Mr. Chairman, we know that the urban, public hospital is serving a vital role for our nation's poor. We know some of the distinguishing characteristics of these hospitals -- they service a disproportionately large percentage of the poor; they are perceived as "second class" institutions, often because of their physical appearance; they provide, at a minimum, acceptable medical care; and they have different staffing mixes which contribute to higher costs.

We also know that in cities which do not have public hospitals, private hospitals compensate to some extent to provide some of the care. However, the total volume of care provided to the medically indigent is less. We know that when state and local officials are committed to the hospital that is "the provider of last resort" in their community, the likelihood that the poor will receive adequate care is increased.

These conclusions end my formal remarks, Mr. Chairman. I will be happy to answer any questions you and other Members of the Subcommittee may have.

Chairman STARK. Thank you.
Dr. Kilpatrick.

STATEMENT OF KERRY E. KILPATRICK, PH.D., DIRECTOR, CENTER FOR HEALTH POLICY RESEARCH, UNIVERSITY OF FLORIDA HEALTH SCIENCE CENTER, GAINESVILLE, FL

Mr. KILPATRICK. Mr. Chairman, and members of the subcommittee, I'm Kerry Kilpatrick, professor and director of the Center for Health Policy Research at the University of Florida.

I'm pleased to have been invited today to discuss problems faced by hospitals in providing care to indigents. It's my understanding that you may be drafting legislation to assist disproportionate share institutions; therefore, I'll comment in detail about a current proposal in Florida to address the same issue.

A small number of hospitals in Florida shoulder a disproportionately large share of the indigent care burden. Eight hospitals provide 33 percent of the approximately $900 million in uncompensated care for the entire State.

Of these eight, all are located in urban areas. Seven are supported to a significant degree through public funds, and five have major teaching affiliations.

To account for 50 percent of the uncompensated care for the State requires only 21 hospitals; more than 200 institutions account for the remaining 50 percent.

This situation led the Florida Legislature in 1984 to create a mechanism to level the playing field and enhance competition in the hospital marketplace. A pool of funds was created from a 1½ percent assessment on hospital net operating revenues. For a variety of reasons, the outflows from that fund have consistently fallen short of the approximately $100 million generated annually from the hospital assessments.

This has led to a cash balance now approaching $180 million.

Since it is clear that current programs have not fully utilized the income of the fund, the question is how best to distribute the surplus. Three possibilities occur.

One, make direct payments to the hospitals.

Two, expand programs to reach individuals.

And, three, provide direct grants to local governmental units.

One of the more important considerations in choosing between these three alternatives is the amount of administrative effort it would take to distribute the monies. Clearly, the approach having the lowest administrative burden is simply to write checks to those hospitals providing the greatest share of uncompensated care.

On the other hand, it's been found that to qualify one individual patient for the State's medically needed program takes approximately 2 hours of a trained social worker's time. This application process, most of which is dictated by Federal requirements, has been budgeted to consume approximately one third of the total income of the fund, thus funds that should be used to offset the cost of providing services to the poor were designated instead to support bureaucratic overhead.

With respect to a plan to distribute funds via grants to local governments, one of the principal shortcomings is the creation of a dis-

incentive for continued contributions to indigent care from those local sources.

Because targeting individuals for assistance from the trust fund has proved to be inefficient, I will concentrate the balance of my remarks on a proposed methodology for making payments directly to hospitals.

The proposed plan would work as follows. For each participating hospital, 8 percent of nongovernmental patient services revenues would be subtracted from their total uncompensated care as that hospital's fair share allowance for bad debt and indigent care.

From the remainder would be subtracted the grants and donations for indigent care, tax revenues, and other appropriated funds. That would yield the net uncompensated care amount for the hospital. After further adjustment, a ratio would be computed of the hospital's uncompensated care to the sum of the uncompensated care for all hospitals in the State. That ratio would then be multiplied times the amount of the fund to be distributed, yielding the payment to the hospital.

For example, if an individual hospital did 15 percent of the uncompensated care in the State, and the fund balance to be distributed were $100 million, then that institution would get $15 million in direct payments.

Several considerations merit further comment.

First, before any distribution method of the type I've described can be attempted either at a State or the Federal level, it is essential that a data system exists which is extremely detailed in capturing hospital revenues and expenses.

Second, although such a distribution will in part reduce the disparity between hospitals, the problem cannot be totally solved by an assessment on hospitals. A fully effective system will also require a contribution from broadly based general revenue sources.

Third, the existence of the distribution should not be taken as a signal to the health care industry to stop its efforts to expand primary care and preventive care. Efforts should be continued to provide appropriate nonhospital settings for problems which can be safely and effectively managed elsewhere.

Conversely, it's important to recognize that even fully expanded primary care programs will not totally eliminate the hospital's problem of uncompensated care. There still must be some explicit mechanism for meeting the needs of that relatively small number of institutions that provide the bulk of uncompensated care to permit those institutions to compete effectively in the health care marketplace.

Thank you.

[The statement of Mr. Kilpatrick follows:]

AN APPROACH TO COMPENSATING HOSPITALS FOR INDIGENT CARE

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Statement before the Subcommittee on Health
of the Committee on Ways and Means, U.S. House of Representatives;
Hearing on Hospital Indigent Care
Washington, D.C.
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Introduction

Mr. Chairman and Members of the Subcommittee: I am Kerry Kilpatrick, Professor and Director, Center for Health Policy Research at the University of Florida. I am pleased to have been invited today to discuss the problems faced by hospitals in providing care to the indigent. It is my understanding that you may be drafting legislation that creates an indigent care fund to be distributed to disproportionate share institutions. Therefore, I will comment in detail about a similar proposal in Florida. I will use the Florida situation to illustrate my remarks, first because it is the state for which I have the best data, and secondly because Florida is often thought of as a bellwether state where trends that will eventually impact the entire nation are seen first.

In Florida, as in many other parts of this country, a small number of hospitals shoulder a disproportionately large share of the indigent care burden. Eight hospitals provide 33 percent of the uncompensated care for the entire state. Of these eight, all are located in urban areas, 7 are supported to a significant degree through public funds and 5 have significant teaching affiliations. To account for fifty percent of uncompensated care for the state requires only 21 hospitals. The other 235 institutions account for the remaining 50 percent. Figure 1 displays graphically the relationship between the number of hospitals and the proportion of indigent care provided.

Table 1 provides selected data on hospital characteristics classified by hospital ownership type and teaching status. In this display the contributions of the teaching hospitals to the provision of uncompensated care are most dramatic. These hospitals provide 21 percent of the uncompensated care, but comprise only 2 percent of the hospitals with 6 percent of the beds and 9 percent of the patient days. Exclusive of the teaching hospitals, the relationship of ownership to the amount of uncompensated care is also of interest. The not-for-profit hospitals compose about 40 percent of the hospitals in the state with 43 percent of the beds, 45 percent of the patient days, and 36 percent of the uncompensated care. Investor-owned hospitals are 43 percent of the hospitals with 37 percent of the beds, 33 percent of the patient days, and 20 percent of the uncompensated care. The government-owned hospitals comprise 15 percent of the hospitals, 13 percent of the beds, 14 percent of the patient days, and 23 percent of the uncompensated care. Thus, the mission of the hospital, as reflected by its ownership type, is related to the amount of uncompensated care provided by the institution.

Creation of the Medical Assistance Trust Fund

Clearly, the burden of providing care to patients who are unable to pay falls disproportionately on a small number of institutions. This situation lead the Florida Legislature in 1984 to create a mechanism to "level the playing field" and enhance competition in the hospital marketplace. To accomplish this end a pool of funds was created from a one and one half percent assessment on hospital net operating revenues. The Public Medical Assistance Trust Fund facilitated the categorical expansion of Medicaid and the creation of a Medically Needy program, and funded a primary care program. In 1984, when the Health Care Access Act was passed, no explicit recognition was given of how to distribute any surpluses from the trust fund if the outflow for the Medicaid expansions did not equal the revenues generated from the hospital assessments. For a variety of reasons, the outflows have consistently fallen short of the approximately $100 million generated annually from the hospital assessments. This has lead to a cash balance approaching $180 million in the fund. As the hospitals in the state are currently experiencing approximately $900 million in uncompensated care annually, the existence of that cash balance has generated considerable interest in developing a mechanism to distribute the funds to those hospitals which provide a disproportionate share of uncompensated care to the indigent.

Alternative Approaches to Distributing the Fund

Now that it is clear that current programs, in the short run at least, have not fully utilized the income of the fund, the question that arises is how best to distribute the funds to the hospitals. Three possibilities occur: 1) to make direct payments from the fund to the hospitals, 2) to expand existing programs and develop new programs to reach individuals who need assistance in paying hospital expenses, and 3) to provide direct grants to the local governmental units most heavily impacted by hospital uncompensated care. The counties or municipalities would then make appropriate payments to the hospitals in their jurisdictions. Each approach has practical strengths and weaknesses as well as political strengths and weaknesses.

One of the more important considerations in choosing between these three alternatives is the amount of administrative effort it would take to distribute the monies. Clearly, the approach having the lowest administrative burden is simply to write checks to those hospitals providing the greatest share of the uncompensated care. On the other hand, it has been found that to qualify an individual patient for the State's Medically Needy program takes approximately 2 hours of a trained Social Worker's time. At the current time, an extraordinarily detailed 12 page form must be completed for each new applicant. This form requires information on household composition, living arrangements, living expenses, income, assets, employment information, and so forth. In actual application, because of the documentation requirements, it may take several visits to the case worker and several months to complete an application. The bureaucratic burden of this application process, most of which is dictated by federal requirements, had been budgeted to consume approximately one third of the total annual income of the fund. It was estimated that over 1,400 new interviewers would be required to staff the application process. Thus, funds that should be used to offset the costs of providing services to the poor were designated instead to support bureaucratic overhead.

With respect to a plan to distribute funds via grants to local governments, one of the principal shortcomings, is the creation of a disincentive for continued contributions to indigent care from local sources. If those local contributions were reduced, the funding problem would be exacerbated.

Because targeting individuals for assistance through the Public Medical Assistance Trust Fund has proved to be inefficient and because the hospitals feel considerable ownership of the funds, having paid the assessment that created the Public Medical Assistance Trust Fund in the first place, the strategy that is being promoted most vigorously during this legislative session is to make direct payments to the hospitals. I

will, therefore, concentrate the balance of my presentation on the proposed methodology for making such disbursements.

Development of a Distribution Method

Before any distribution method can be attempted, either at a state or national level, a data system must exist which is extremely detailed in capturing hospital revenues and expenses. To attempt to develop a distribution methodology in absence of a detailed, audited data base such as exists in Florida would seem to me to create an opportunity for the inefficient or inappropriate allocation of the pooled funds.

In the discussion which follows, I refer to uncompensated care as the sum of charity care and bad debt. While it is theoretically possible to define charity care as free care given to persons below a certain income level or meeting certain income and asset tests, in reality the distinction between charity care and bad debt is frequently blurred. Principally for this reason, the hospital industry in Florida, I think wisely, has chosen to base its proposal on target levels for total uncompensated care. The proposed solution in Florida which has the support of the entire hospital industry is outlined in Figure 2.

For each participating hospital, charity uncompensated care plus provision for bad debts is summed to yield an uncompensated care amount. From this amount is subtracted a percentage of gross patient care services revenue that the industry agrees all hospitals should be willing to contribute toward uncompensated care. The final version of this proposal has yet to be fully worked out, but the operating percentage at the moment is 8 percent of non-governmental patient services revenues as the hospitals "fair share" allowance for uncompensated care. The 8 percent figure includes a 5 percent allowance for bad debt and a 3 percent minimum requirement for indigent care.

Subtracting that 8 percent allowance yields an uncompensated charity care amount from which is subtracted any restricted grants and donations for indigent care that the hospital may have received plus unrestricted tax revenues and appropriated funds coming from tax district or county sources. That yields a gross uncompensated care amount for the hospital. To that number is applied a Medicaid collection rate cap so that no institution would receive more funds per patient day for uncompensated patients then they would have received had that patient qualified for the State Medicaid program. Once that cap is applied, the ratio of the hospital's uncompensated care amount to the sum of all similar amounts for all participating institutions in the state is taken. That ratio then is multiplied times the amount of the fund to be distributed, yielding a provisional cash payment for the hospital.

For example, if a individual hospital did 15 percent of all uncompensated care in the state and the fund balance to be distributed is $100 million, then that institution would get $15 million in direct payments unless capped by the Medicaid rate. Some of the details of the timing of the distribution have yet to be worked out, but that in essence is the system that has been proposed by the hospital industry.

The Florida legislative committees which deal with health care issues most likely will seek a modification of the proposed hospital formula. Early indications are that the legislature may, in fact, be more stringent in its definition of the disproportionate share hospital. This will make the distribution less broadly based than that originally proposed by the industry and, consequently, target more closely those hospitals that provide the largest amounts of uncompensated care.

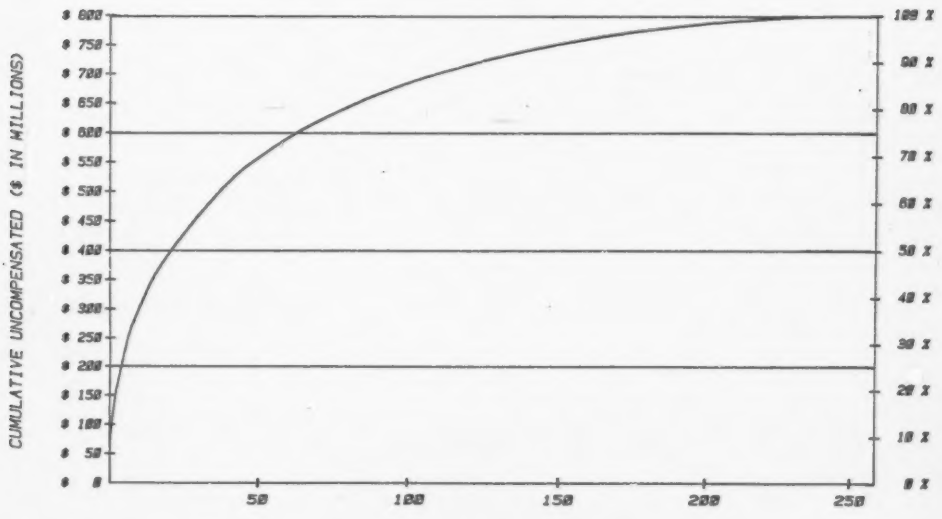
Further Considerations Relative to the Distribution Method

Although the distribution of the trust fund to the hospitals will, in part, reduce the disparity between hospitals that provide a significant amount of uncompensated care and those that do not, the problem will not be totally solved at the current level of the hospital assessment. An assessment considerably larger would be required to fund

fully all uncompensated care. As operating margins in many segments of the industry are not strong, assessments of that level would be excessively burdensome on many hospitals. This suggests that a fully functional distribution system will also require contributions to the fund from broadly-based general revenue sources.

A second consideration is that the existence of the distribution method should not be taken as a signal to the health care industry to stop its efforts to expand primary care and preventive care in those areas where such expansion is warranted and demonstratively will reduce unnecessary hospital admissions or emergency room visits. Clearly, efforts should be continued to provide appropriate non-hospital settings for problems which can safely and effectively be managed in these other settings. Conversely, it is important to recognize that even fully expanded primary care programs for persons who cannot afford to pay for their medical care will not totally eliminate the hospitals' problem of uncompensated care. There still must be some explicit mechanism for meeting the needs of that relatively small number of institutions that provide the bulk of the uncompensated care to permit those institutions to continue to compete effectively in the health care market place.

FIGURE 1
DISTRIBUTION OF UNCOMPENSATED CARE
FLORIDA 1985



SOURCE :
FLORIDA HOSPITAL COST CONTAINMENT BOARD
UNIFORM REPORTING SYSTEM, 1985 ACTUAL

TABLE 1

Percentage Distribution of Uncompensated Care
and Characteristics by Hospital Type

Type	Uncompensated Care	Number of Hospital	Total Beds	Patient Days
Government Owned	23.4	15.2	13.5	14.2
Investor Owned	19.9	43.4	37.4	32.6
Not for Profit	35.8	39.4	43.1	44.7
Major Teaching	20.9	2.0	6.0	8.5
Total	100.0	100.0	100.0	100.0

Source: Florida Hospital Cost Containment Board Uniform Reporting System, 1985 Actual.

FIGURE 2

Florida Hospital Industry Proposal for
Distribution of the Public Medical Assistance Trust Fund

1.	Charity/Uncompensated Care
2. PLUS	Provisions for Bad Debts
3. EQUALS	Gross Uncompensated Care
4. MINUS	8% of Gross Patient Care Services Revenues (Non-Governmental)
5. EQUALS	Net Charity Care
6. MINUS	Restricted Donations and Grants for Indigent Care
7. MINUS	Unrestricted Tax Revenue and Appropriated Funds
8. EQUALS	Gross Uncompensated Care Credit
9. DIVIDED BY	Gross Revenue Per Adjusted Patient Day
10. EQUALS	Uncompensated Care Credit Days
11. TIMES	Medicaid Per Diem
12. EQUALS	Medicaid Collection Rate Cap
13.	Net Revenue - Restricted Grants and Donations
14. DIVIDED BY	Non-Indigent Gross Revenue
15. TIMES	Gross Uncompensated Care Credit
16. EQUALS	Allowable Net Uncompensated Care
17.	Amount Available for Distribution
18. DIVIDED BY	Sum of all Hospitals' Allowable Net Uncompensated Care (Line 16)
19. EQUALS	Distribution Rate
20. TIMES	Allowable Net Uncompensated Care (Line 16)
21. EQUALS	Interim Hospital Payment
22.	Final Hospital Payment = Minimum (Line 12, Line 21)

Chairman STARK. Thank you.
Dr. Rucker.

STATEMENT OF LLOYD RUCKER, M.D., ASSOCIATE CLINICAL PROFESSOR OF MEDICINE, DIVISION OF GENERAL INTERNAL MEDICINE AND PRIMARY CARE, UNIVERSITY OF CALIFORNIA/IRVINE, IRVINE, CA

Dr. RUCKER. Thank you, Mr. Chairman, members of the committee.

I am Lloyd Rucker. I am an internist and associate professor in the Department of Medicine, University of California/Irvine.

At one time California had over 60 public hospitals. Today barely 30 remain. One of those lost was the Orange County Medical Center. Today I would like to describe the reasons for the county's sale of the hospital, the subsequent history of the medical center, and the ramifications of these events for the medically indigent of Orange County, CA.

For the 75 years prior to 1975 the County of Orange operated its own public hospital. Although care was not strictly free, the hospital offered open access to residents of the county regardless of ability to pay, or of citizenship status. In the early 1970's, as you know, health care costs began to rise dramatically. In addition, the State decreased funding for indigent health care, and tightened Medicaid eligibility restrictions. Faced with large deficits, the county decided to sell the medical center to the University of California at Irvine.

The sale of the hospital did not decrease the financial stresses on the institution. Although technically now a private hospital, the university still served most of the medically indigent in the county, and indeed had the highest proportion of medically indigent patients of any non-public-university hospital in the country. Further cuts in Medicaid and refusal of the county government to provide adequate indigent medical care funding led to increases in deficits. By early 1980's the hospital began to face deficits of nearly $10 million. Hospital administration at that time markedly cut services and decreased staffing levels to a bare minimum. They initiated a positive policy which effectively eliminated the access to the medical center for many of the medically indigent.

However, even these measures had no impact on the deficits, and, in fact, could not have been expected to. Seventy percent of the university hospital's patient population continues to be medically indigent individuals for whom State and county inpatient reimbursement rates are approximately 20 to 50 percent below actual costs.

Our group at Irvine conducted a study of the effects of changes in university, county, and State indigent medical care policies on the health of the medically indigent in our county. We studied a group of 200 individuals who had come to county eligibility workers seeking public assistance in obtaining health care. We define the specific health care needs of these patients, and then followed a randomized group of these patients to determine whether they were able to obtain access to health care once refused public assistance.

The average age of the population is 37 years old; 60 percent had incomes of less than $500 per month. The survey showed that over 70 percent had a significant likelihood of long-term disability from a treatable medical condition. These conditions included cancer, high blood pressure, athrosclerotic heart disease, asthma, breast cancer, diabetes, kidney stones, high risk pregnancies, and fractures of the bone. Sixty-two percent of those patients with the most severe illnesses were not able to obtain care in the community once having been refused public assistance.

One representative patient was a 55-year-old aerospace engineer laid off by his company. Two weeks after losing his job he suffered a heart attack. Without insurance he accrued over $15,000 in debt, and markedly depleted his personal assets. However, for the sake of his wife and family, he refused to divest himself of his retirement funds. And, therefore, was not eligible for county assistance. University Hospital was stuck with a large bill. The patient now sits at home not able to obtain medical care, experiencing daily chest pains, and not able to return to work because of his medical condition.

Another patient was a Guatemalan woman on a legal visitor's visa, who developed bleeding and was found to have cervical cancer. As a legal visitor she was not eligible for care. So she essentially became a nonperson, probably by buying an exit stamp from a Customs official, became illegal, and was able to obtain care temporarily, and illegally under emergency provisions of the California Medicaid law. Still a third patient was a 48-year-old woman who developed severe weakness from a neurologic disease. She was self-employed and not insured. Her husband and she were literally bankrupt by her illness. Losing their small business and virtually all of their assets before becoming eligible for county assistance. Prior to 1975 under the auspices of the old county program, all of these patients would have received care at the county hospital without first having to become destitute. Today they obviously cannot. The University Hospital continues to face large deficits. The Governor has proposed a 10-percent cut in Medicaid reimbursement to physicians, and the county has thus far refused to supplement its relatively meager indigent medical services funds. Other studies conducted in Orange County have corroborated our findings, and documented decreased access to health care, and in some cases, worsening of health care conditions. The prognosis for the University Hospital as the primary provider of indigent medical services and for the health of the medically indigent themselves, remains guarded. Thank you.

Chairman STARK. Doctor, I guess what I am hearing you say is that there is no county hospital in Orange County.

Dr. RUCKER. Exactly.

Chairman STARK. Or there is no public facility.

I guess—are there other counties in California where that situation exists. Are there other counties?

Dr. RUCKER. There are other counties without——

Chairman STARK. Susanville, maybe.

Dr. RUCKER. I am not sure which ones they are, but——

Chairman STARK. There are some counties way up in the north that are pretty remote.

Dr. RUCKER. Most of the large counties have county facilities.

Chairman STARK. Well, it is a strange and wondrous State.

Ms. Henderson, I am a little confused. You talk about a typical city, and you translate your data, saying that there would be 4,000 more admissions for the poor if the city had a public hospital.

Now, in Irvine—and I am not sure that is a typical U.S. city—is this just because people stay home and suffer? Is that what you are saying? Or have they tried to get in and not been able to get in? I am not quite sure what that means. If you have a charity or a county hospital which is there to provide for the poor, obviously people are going to use it, and if you do not——

Ms. HENDERSON. Where do they go?

Chairman STARK. I suppose, they go over to the neighboring county.

What does that mean to us aside from the fact that if there is, as Dr. Rucker points out, no county hospital?

Ms. HENDERSON. I think that is certainly a question that occurred to us when we saw just the raw data from our study. And unfortunately, to do the kind of studies that have been talked about here is an expensive matter, to try to track of where people actually go.

I think in Tampa we were struck by the fact that the admissions in the public hospital decreased markedly over a relatively short period, a 2 or 3—actually, a 2-year period. And the question was, where were these patients going?

There was some feeling that they were going to other parts of the State to obtain care, and there was also the perception that they just were not receiving care. Perhaps they were delaying care, and it would become a pent-up problem, and perhaps at some later stage they would come back into the system one way or another.

Chairman STARK. Is this not basically a problem that we will face if we encourage profitmaking hospitals and/or if we encourage capitation programs? Unless the requirement for qualifying for Federal assistance in the capitation program is that you have to have open season all the time. In other words, if you let the capitated system cherry-pick, they are going to leave the less desirable and less profitable cases to the public, and if the public is not providing any system, our traditional system somehow breaks down.

I do not know what this portends for us.

Mr. Levin.

Mr. LEVIN. I am just trying to assimilate this testimony, Mr. Chairman. Much of it speaks for itself.

Dr. Rucker, when you say on page 2 that over 70 percent of this group of 200 individuals, had a significant likelihood of long-term disability from a treatable medical condition are you saying, of the 200, 70 percent had a condition like those you enumerate?

Dr. RUCKER. That is right, yes.

We were very careful in the study to rate the patients according to whether medical treatment would make a difference.

Mr. LEVIN. Seventy percent had a condition such as cancer, high blood pressure, heart disease, asthma, breast masses—you said cancer as you read it—kidney stones, diabetes, high-risk pregnancies, and bone fractures.

Is your guess that if this kind of a sample were done scientifically in the rest of America, we would find the same result? It is an unscientific question, I sense, but what is your——

Dr. RUCKER. I think you would find the same kind of distribution of illnesses. I think that one of the things that we were able to demonstrate was that people who had minor illnesses, people that had colds, could get access, because it was not very expensive to treat a cold. It is expensive over years and decades to treat diabetes or high blood pressure or especially financially devastating illnesses like cancer. The people that had those illnesses were not able to get access. I think the distribution would be pretty much the same in the general public.

Mr. LEVIN. Could you supply us details? I assume you have lots of the basic data available for us to see, so we could see what the distribution of these ailments might be.

Have there been other studies in the United States like this?

Dr. RUCKER. None exactly like this that I am aware of. There have been studies, there was a study done at UCLA on examining a group of patients who were cared for under the MediCal system, and then in 1983 the MediCal noncategorical patients were transferred to county responsibility. And when those counties were—those patients were transferred from State responsibility to county responsibility, they were able to demonstrate that their blood pressures, which had been formerly controlled, went out of control; that their diabetes, which was formerly controlled, went uncontrolled, and some people died from strokes, presumably due to uncontrolled blood pressure.

So aside from that study and studies of broad-based populations, like infant mortality data, which show deteriorations and all, but nothing specifically along the lines.

Mr. KILPATRICK. Mr. Levin, if I may interject, we did a study in Florida of all uncompensated care done by the hospitals there, a 100 percent sample of hospitals, and a 100 percent sample of patients, for a month. This sample of nearly 14,000 cases provides the distribution of diagnoses that resulted in an uncompensated care amount.

Those findings would indicate that it is very difficult to extract a single type of diagnosis or DRG that accounts for uncompensated care. Nearly all diagnoses were represented in that study, and the top diagnosis, the top DRG, was just normal deliveries, and that only accounted for 4 percent of the patients and 1.3 percent of charges. In fact, the top 10 diagnoses, if you summed them all up, would only get you about 15 percent of all the charges.

So it is very widely spread. It is very difficult to target a single diagnosis to go after.

Mr. LEVIN. Well, but I am not sure what you think the import of that fact is. I mean, what Dr. Rucker is saying, and I assume he has stated it conservatively or carefully, that over 70 percent of this group of 200 had a significant likelihood of long-term disability from a treatable medical condition.

Mr. KILPATRICK. Well, the significance of the fact that I was stating was that if you had a program particularly targeted for one diagnosis, like an improved pregnancy outcome program, for exam-

ple, as effective as that program might be, it is only going to solve a very small portion of the hospitals' uncompensated care problem.

Mr. LEVIN. I see. So it has to be done comprehensively.

Mr. KILPATRICK. Absolutely.

Mr. LEVIN. Thank you.

Chairman STARK. Mr. Moody?

Mr. MOODY. Thank you.

I was interested in the distribution of uncompensated costs by type of hospital. It seems clear that the teaching hospitals proportionally bear the highest portion?

Mr. KILPATRICK. That is correct.

Mr. MOODY. Relative to their——

Mr. KILPATRICK. Proportionally, relative to their numbers, yes.

Mr. MOODY. What policy conclusions develop from that?

Mr. KILPATRICK. Well, there are several policy conclusions. One, of course, the teaching hospitals are the higher cost institutions, and I think that we can ferret out from their high costs the proportion that is due to teaching. That is not easy, but certainly their uncompensated care is not a teaching cost directly, and to keep those institutions providing the service they provide, that uncompensated care problem has to be addressed head on.

Mr. MOODY. That is interesting, but what I would like to try to get at is if you think there is some selection of diagnostic grouping into this hospital that——

Mr. KILPATRICK. Oh, there is no question, there is no question that there is greater case severity that leads to their high charges, which makes them less competitive in the marketplace.

Mr. MOODY. The other thing you said I thought was interesting that your statement covers is that one third of the total amount of income from your uncompensated care fund in Florida goes to the bureaucratic overhead of filling out the forms?

Mr. KILPATRICK. That was what was budgeted, yes, sir. It never fully got up to that amount, but the Department of Health and Rehabilitative Services was planning to hire something like 1,400 case workers just to implement the program.

Mr. MOODY. Good heavens. And you say here that most of that is required by the Federal Government?

Mr. KILPATRICK. The state is very conservative in meeting the Federal Government's requirements for the Medicaid program. They do not want adverse audit. So they are very conservative in qualifying individuals for that program.

Mr. MOODY. Just the Medicaid?

Mr. KILPATRICK. Also for the medically needy program, which was also under the Medicaid statutes.

Mr. MOODY. Have you compared this form with the forms other States are using without adverse audit?

Mr. KILPATRICK. I have not, sir.

Mr. MOODY. Maybe that would be interesting to hear.

Do you recommend that we try to reduce the burden of federal detail here?

Mr. KILPATRICK. I think it would certainly help to ease that burden in qualifying individuals and getting the money to the target that you are aiming for, yes, sir.

Mr. MOODY. Thank you.

Chairman STARK. Dr. Kilpatrick, you mentioned that a tax on the gross revenues of hospitals or net——

Mr. KILPATRICK. Net operating revenues. Net operating revenues, so if a hospital did not make any net revenue it would pay no assessment.

Chairman STARK. Are there other taxes employed on hospitals? Is there a room tax on a hospital, or is this——

Mr. KILPATRICK. This assessment was a special assessment to fund the Health Care Access of 1984.

Chairman STARK. And that is the only tax, so I will refer to it sometimes gratuitously as a room tax, but it is actually——

Mr. KILPATRICK. It is not a similar tax to that, sir.

Chairman STARK [continuing]. Net, gross income tax, so to speak.

Mr. KILPATRICK. Yes.

Chairman STARK. Did Florida, in their political debate, consider a premium tax on health insurance plans as an alternative?

Mr. KILPATRICK. Yes, a full range of alternatives was considered, including increasing the State sales tax. This assessment at the time, was the most politically feasible.

Chairman STARK. It is in fact adding a tax to the sick, is it not?

Mr. KILPATRICK. Well, it is referred to as a sick tax by the hospitals, that is correct.

Chairman STARK. The hospital generally would have favored something else?

Mr. KILPATRICK. They would have favored something else, but as it was posed to them in that setting, the alternative was rate regulation, and they preferred this.

Chairman STARK. Dr. Rucker, I cannot resist the temptation, as I hear your outline I am just incredulous—are you a practicing physician?

Dr. RUCKER. Yes.

Chairman STARK. Okay. Well, I may have to tar you with this brush, and I apologize. But every physician that I have met, privately or in testimony, has indicated to me that right after the number of hours they spend worrying about overhauling the left engine on their Beechcraft, or polishing their Porsche, or catching up on their approach shots or their net gain, the next thing they spend the most time on is service, charitable service, to take care of indigent people. Every doctor that has come into my office would have me think that they spend a third of their time doing this.

What happened to Orange County?

Dr. RUCKER. I got rid of my Beechcraft last year, so I have a lot more time for that now. But Orange County's hospital, prior to about 1970, was basically a voluntary hospital. It had a staff, full-time staff, of 14 or 15 physicians, and everybody else was a volunteer. It was, at that point, it was 500-bed facility, so that——

Chairman STARK. So they were doing it?

Dr. RUCKER. They were doing it.

When the hospital was sold to the university, and the university brought in its own faculty and full-time staff, and now there is a small amount of that which goes on, but not very much. I——

Chairman STARK. So you, if I can interpret, are saying that there is a willingness on the part of the brethren in your profession to provide it, but there is little focus to it?

Dr. RUCKER. Well, it might be a bit grandiose to say that it is still there. Times have changed. There were expectations about what physicians were supposed to do 20 years ago, and what their obligations to their profession and community were, which I do not think necessarily exists anymore. Part of the problem is—part of the reason is the programs that we have instituted, and we have said that health care is a right, but we have also said that doctors have a right to get paid for it, and that was the other side of the Medicaid message.

And I think now there is a lot less willingness to provide that uncompensated care.

The other side of that issue——

Chairman STARK. Could I push that question just a bit further then? In other words, are you suggesting that maybe we should not depend on the eleemosynary tendencies of the profession, but we should pay up front for the services they provide, just as they pay Congressmen? Everybody in my district wishes I were working for free, but what we have really said is let us pay for the services provided——

Dr. RUCKER. We have said that, and we have come to accept it. I think there would still be a certain amount of charity care which would be delivered.

The problem also is, though, that when you take somebody—when you take care of somebody in your office and go to see them in the charity hospital, and the most complex examination you had was a $20 chest x ray, and nurses only got $5 a hour, it was a lot easier to take care of people, to do charity care. Now, when the quality of care demands that you do $500 CAT scans and nurses make, justifiably, a lot more money, and it costs $700 a day to keep a patient in our hospital, you cannot—it is nice to have volunteer physicians who give up their $20 fee for that day for taking care of the patient, but somebody has to pay the other $700 that it takes to take care of that.

And I think physicians would be willing to do more volunteer work in the right context, especially if their malpractice costs were covered, but it is the rest of the health care which I think is the problem.

Chairman STARK. Would it not be a lot more efficient, for a physician in this country to know that it would be next to impossible for a citizen to not have some kind of insurance, so they could go ahead and bill their fee and do their work and not feel that they were demeaning the patient by suggesting that that patient was a charity case——

Dr. RUCKER. I think that is obvious.

Chairman STARK [continuing]. And go ahead and do what they do best.

Dr. RUCKER. That is how it works in Canada, and I think it works very effectively there.

Chairman STARK. Thank you.

I want to thank the panel very much for their contribution, and appreciate your taking the trouble to enlighten us today.

Our next witness is Barbara Shipnuck, chairman of the Subcommittee on Critical Issues in Public Health, and a supervisor of Monterey County.

Welcome to the hearing. You come from that great area of California so ably represented by my friend and colleague, Congressman Panetta, and I am sure he would join me in welcoming you to the committee today.

Your prepared testimony will appear in the record. You are representing tha National Association of Counties?

Ms. SHIPNUCK. Yes, Mr. Chairman.

Chairman STARK. And you might like to expand on or enlighten about the delights of Cannery Row or other parts of your great county as you see fit.

STATEMENT OF BARBARA SHIPNUCK, SUPERVISOR, MONTEREY COUNTY, CA, AND CHAIR, SUBCOMMITTEE ON CRITICAL ISSUES IN PUBLIC HEALTH, NATIONAL ASSOCIATION OF COUNTIES (NACo)

Ms. SHIPNUCK. Thank you, Mr. Chairman.

I very much appreciate the opportunity to be testifying before the committee this morning, and want to thank you and the other distinguished members of the committee for having this hearing, because this issue is something the counties are most concerned about.

Very briefly, I just would like to summarize my written testimony in saying that counties have a vital stake in the entire issue of indigent hospital-based care. We are the providers of last resort for the poorest and sickest of the population.

Counties operate nearly 900 county hospitals around the country, and spend over $25 billion on health care services each year. NACo's policy platform declares that indigent health care is a top priority of counties today.

Counties are doing what they can to meet a growing local need for health care services. In my county, Monterey County, of the $20 million hospital budget, $5 million of that is county general fund money.

Milwaukee County provides over $27 million to cover bad debt in its medical facility. Jackson County, Miss., allocates about $50 million biennially to support indigent care at Truman Medical Center. Guilford County, N.C., invests $10 million a year. Dallas County, Tex., writes off approximately 71 percent of its gross patient revenues at Parkland as charity, bad debt, and contractual allowances.

And Dade County provides over $17 million to subsidize uncompensated deliveries. These are just a few examples of what is going on across the country as it pertains to county costs and the provision of uncompensated care.

County hospitals, furthermore, are doing what no one else wants to do. They operate neonatal intensive care units, burn centers, trauma centers, and other high-cost, low-yield services that the private sector no longer wishes to subsidize. These are essential services, but are seldom money-makers.

County hospitals serve populations that private facilities do not want, the poor who cannot pay for their services and are uncovered by insurance, the non-English-speaking minorities, the homeless including the chronically mentally ill, low-income alcoholics and drug abusers, undocumented aliens, an increasing number of AIDS

victims, and others who lack resources or social acceptability and who fall through the safety net.

Counties have acted responsibly in containing mounting costs of care. We have experimented with different alternatives. We have promoted prenatal care, teen pregnancy prevention, health education, and other preventive measures, and developed outpatient clinics and encouraged their use instead of relying on the emergency room to gain access to the health care system.

Despite our efforts, counties remain under serious financial stress in providing needed health care. Indigent care through county government is largely funded through the property tax, a nonelastic source of revenue, and one that is increasingly unacceptable to the voters.

Federal assistance is decreasing. Counties lost $4.6 billion in general revenue sharing last year, much of which was targeted to the provision of health care services, or in counties that did not target it that way it freed other dollars for the provision of health care services. Federal grants to State and local governments have dropped by 23.5 percent since 1980. In California the shift of the medically indigent adult population to counties cost us 30 percent of their funding 4 years ago.

It is our firm belief that we must retain the historic partnership between all levels of government, and that the private sector must be involved. The problem is a national problem, cutting across local jurisdictional lines. The Federal Government must recognize its role as the chief financier of public health programs, because it can more equitably allocate resources, has a greater funding capacity through a variety of revenue-producing mechanisms, and its policies, whether of engagement or disengagement, have a dramatic effect on county financing of indigent health care.

Thank you, Mr. Chairman, and NACo and our committee and counties in California particularly stand ready to assist in any way that we can in meeting this challenge.

[Statement of Ms. Shipnuck follows:]

STATEMENT OF THE HONORABLE BARBARA SHIPNUCK, SUPERVISOR, MONTEREY COUNTY, CALIFORNIA, BEFORE THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U. S. HOUSE OF REPRESENTATIVES, WASHINGTON, D. C., MARCH 12, 1987:

Good Morning, Mr. Chairman and distinguished members of the Subcommittee.

For the record, I am Barbara Shipnuck, a member of the Board of Supervisors of Monterey County, California. I am appearing before you today in my capacity as Chair of the Subcommittee on Critical Issues in Public Health of the Health and Education Steering Committee of the National Association of Counties (NACo).*

NACo appreciates this opportunity to be here today to comment on the problems surrounding the provision of hospital care to indigents. We commend the Subcommittee for undertaking this review and offer you our support in working toward a solution to this complex problem.

Counties have a vital stake in the outcome of your deliberations. We are, as you well know, the health care providers of last resort for the sickest and poorest of our constituents--the estimated 35 million Americans who are either uninsured or underinsured, those who fall through the social safety nets of Medicare and Medicaid. Counties are the providers, financiers, planners and purchasers of health care services for the elderly, pregnant women, children, mentally ill, illegal aliens and others who have no where else to turn for assistance in obtaining essential, life-sustaining treatment. We operate over 900 county hospitals, numerous nursing homes, clinics, and health departments. Any decision which impacts on the accessibility to care for the poor directly affects each of the over 3,000 county governments in this country.

That is why NACo's policy platform declares "the issue of indigent health care costs to be a top-priority health care issue facing counties today." As health care costs have continued to escalate and Federal budget-driven reforms have cutback on traditional financial supports available to communities, counties have become acutely aware that the protective mantle of local governmental health care assistance to the poor is becoming frayed and threadbare. Faced with conflicting financial pressures, distressed counties are searching for ways to relieve the mounting indigent care burden they are called upon to bear. More and more counties, which once operated public hospitals of their own, have either sold their facilities, closed them down, or turned to private managerial firms to try to restore them to fiscal solvency. A number of factors, which will be addressed later, have led them to follow this path.

Before getting into this area, however, I would like to assure you that county commissioners and supervisors around the nation are fully sympathetic with the difficult problems which confront you as you attempt to deal with the two-headed hydra of severe domestic problems and a mounting deficit. As elected officials who are also responsible for budget integrity at the local level, we can appreciate your struggle to control the deficit.

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* The National Association of Counties (NACo) is the only national organization representing county government in the United States. Through its membership, urban, suburban, and rural counties join together to build effective, responsive county government. The goals of the organization are to: improve county government; serve as the national spokesman for county government; act as a liaison between the nation's counties and other levels of government; and achieve public understanding of the role of counties in the federal system.

But we are here today to share with you our perception of what is happening at the local level in relation to hospital indigent care. It is at the local level that the human face of indigent health care is most evident. National policies and priorities are reflected in the fears and hopes of those who come through the doors of county hospitals seeking care and treatment. We see the results of the macro-decisions as more than statistics. We see them as real people, who either receive or are denied the health services they need.

NACo believes that county governments have shouldered their fair share of the burden of caring for the poor and are now stretched to the limit in their capacity to respond to an ever increasing human need for adequate health care. It is not a lack of will which leads us to this circumstance, but, rather, a serious lack of resources and a breakdown in the historic partnership between all levels of government and the public and private sectors in meeting the need through our common endeavors. Our platform asserts--with ample justification, in my judgment--that counties "must receive adequate reimbursement for the higher costs incurred in treating the more seriously ill patient with multiple problems, including the medically indigent, the mentally ill, and those suffering from alcoholism and drug abuse, and in providing needed services which are often unavailable in other institutions." What we are witnessing, however, is a dangerous tendency to move in the opposite direction, to further cut resources to help balance the budget, to strangle those remaining public facilities which continue to pick up the pieces of a shattered health care partnership.

County governments have seen a steady erosion of Federal assistance which formerly helped them balance competing community needs for education, infrastructure development, transportation, corrections, social services, and health care. Last year witnessed the demise of General Revenue Sharing, which would have provided counties and cities with $4.6 billion to use according to locally-determined priorities. In Los Angeles County, the entire GRS allotment of $80 million was devoted to indigent care. Other counties may have applied their funds differently, but the flexibility of this program enabled them to better respond to health care needs by relieving countervailing financial stresses throughout their budgets. The loss of GRS was a stunning blow to local units of government and has implications which are only now beginning to surface.

But General Revenue Sharing's elimination is not an isolated phenomenon. It is symptomatic of a broader and disturbing trend of Federal disengagement from domestic responsibilities. Other forms of national assistance to local governments have also been drying up. A 1985 report by the Congressional Research Service revealed that inflation-adjusted grants from the Federal government to state and local governments decreased by 23.5 percent between 1980 and 1985.** To control expenditures, the Administration and Congress have tightened eligibility requirements for various health care programs, reformed hospital payment systems, and instituted cost containment measures. Proposals have been advanced to "cap" Medicaid, which would aggravate the uncompensated care problems faced by counties. The Health Care Financing Administration is moving to disallow Medicaid reimbursement to county nursing homes which are serving mentally ill persons. It seems like everywhere we turn, counties are being told that indigent care is "our problem" and that we must find the solution.

** Rymarowicz, Lillian, and Zimmerman, Dennis, "The Effect of Federal Policies on the State-Local Sector," Congressional Research Service Report No. 85-214E, November 20, 1985, P.7.

I do not mean to imply, Mr. Chairman, that the Federal government has completely turned its back on us. Counties know that the Congress has been struggling with this dilemma. We are deeply appreciative of your willingness to adjust public hospital payments to recognize the extraordinary costs associated with serving a disproportionate share of indigent patients. We applaud your defense of the entitlement nature of Medicaid against efforts to convert it to a block grant and shift more of the burden to local entities. In many ways, the Congress has been sensitive to county concerns, but the reality is that the problem persists despite all of our previous best efforts. And today, what is truly lacking is the confidence--the certainty--that the Federal government will be there when the going gets rough, that the partnership between all levels of government will continue to meet the challenges confronting us. We know that we cannot do it alone. Without strong Federal involvement in the financing of health care to indigents, county hospitals serving the poorest and sickest among us will become impossible to maintain.

We are not talking about small change here, Mr. Chairman. Counties already spend over $25 billion on health care each year. In my county of Monterey, the Natividad Medical Center (our county hospital) has an annual budget of $20 million, $5 million of which is provided by a General Fund subsidy. Places like Milwaukee County, Wisconsin, provide in excess of $27.1 million to cover bad debt and indigent care in their medical complex. In Jackson County, Missouri, the Truman Medical Center provided $50 million of uncompensated care over a recent two year period. Guilford County, North Carolina, devotes $10 million annually for indigent care, with additional county funds being used as match for the state's share of Medicaid costs. Dallas County, Texas writes off approximately 71% of Parkland Hospital's gross patient revenues as charity, bad debts and contractual allowances. Dade County, Florida, provides over $17 million per year just to cover the costs of bad debt and charity deliveries in its county hospital. In county after county, from the sunny coast of California to the eastern shores of Maryland, from the arid Southwest to the windswept plains of the prairie states, the story is the same. Counties are dedicating enormous and growing segments of their local budgets to assuring access to needed health care for the poor. In some states, counties are even required to put up part of the state's share of the Medicaid match.

For counties operating their own hospitals, the problem is particularly critical. Some of our hospitals devote as much as two-thirds of their budgets to cover uncompensated care. In a recent survey, the National Association of Public Hospitals (NAPH) found that, on average, 60% of its member hospitals' revenues were derived from Medicaid and direct state or local appropriations. NAPH's membership includes many of our larger county facilities. High-cost, low-yield medical services, like neo-natal intensive care and burn centers, are being dropped by profit-driven institutions, leaving public facilities to inherit the patient load and financial liabilities. In the Fall, 1984 issue of "Metropolitan Hospital," Frank Sloan, Centennial Professor of Economics at Vanderbilt University, reported that 53 percent of self-pay and no-charge hospital patients were accounted for by maternity and accident cases. Our hospitals tend to serve higher numbers of teen-age pregnancies, since many of these young women are on public assistance or unable to pay for their deliveries. They are also at high risk of giving birth to low-birthweight infants who may require expensive intensive care. For persons who do not have access to a family physician, the emergency room at the public hospital is still too often viewed as the entry point to the health care system.

You might be surprised to know, Mr. Chairman, that in Shelby County, Tennessee, it is estimated that 100 girls under age 15 gave birth to infants in 1986, and for some it was not the first child. In a sample of 11 counties we surveyed, Shelby County fell in the middle of the respondents in the number of children having children. In Guilford County, North Carolina, 58.1% of all births to girls under age 15 were low birthweight, compared to 18.7% for the general population. In Allegheny County, Pennsylvania, 17.1% of the girls under 15 giving birth delivered low birthweight infants, while the county average for all ages was only 6.4%. Clearly, these youngsters are at high risk of needing neo-natal intensive care for their infants. In my county, Mr. Chairman, that translates into an average cost of $72,500 per infant in intensive care, with the county's share averaging $42,075. I cannot imagine that many proprietary hospitals encourage 12 year old mothers to deliver in their facilities. But county hospitals are expected to perform this essential service despite the financial risks.

Public hospitals have also reaped the chaff of reform, while others have harvested its benefits. If we look for a moment at what has happened over the past few decades, we can see dramatic changes in the delivery of health care services in this country. At one time within the memory of us all, most hospitals would accept "charity" patients as a matter of course, shifting the costs of uncompensated care to paying patients. There was a hidden subsidy which permitted health care institutions to share the burdens of indigent care on a more equitable basis. But concerns over cost containment brought in a variety of mechanisms like DRG's and capitation plans, HMOs and PPOs, which altered the marketplace and made it more competitive. The traditional allocation of cost centers within a hospital setting changed to reflect a more realistic relationship between a service and its cost. Hidden subsidies were exposed and, in the for-profit sector, largely eliminated. The "bottom line" of fiscal restraint made it increasingly difficult for private sector hospitals to continue to provide "charity" care to any significant degree. As these hospitals became leaner and more efficient, they were forced to harden their attitudes toward the provision of indigent care. Cost containment was successful in reducing unnecessary hospitalization, enhancing competitiveness, and producing other laudable results, but, like the moon, it had a dark side that was visible only to those who stood in its shadow. And, Mr. Chairman, it was the poor who huddled there.

Under pressure to cut costs, private hospitals increased the number of indigent patients they transferred to public facilities. Instead of shifting costs for charity care internally, they externalized this cost by moving non-paying patients into county hospitals, where local taxpayers could pick up the uncompensated costs. In its more blatant manifestation, this practice consisted of literally "dumping" someone on the doorstep of a public institution, regardless of the critical nature of a person's medical condition. Fortunately, the last Congress enacted legislation which should prevent some of the worst abuses of this practice. But despite the "anti-dumping" legislation, it seems likely that private hospitals will continue to transfer medically stable patients to public facilities to avoid "bad debt" write-offs. Locally-run institutions will inherit those indigents which the private sector cannot or will not serve.

NACo believes that the provision of health services to the uninsured and underinsured is a shared county, state, Federal government and private sector responsibility and that remedies to the problem must come from a joint effort by these sectors. Our Association argues that adequate health benefits must be made available to the whole population, regardless of residence or socioeconomic differences. But what is clearly being sucked into the maelstrom of reform is the notion of equal access to health care for all.

If the Federal and state governments and the private sector abandon the indigent and medically needy to county hospitals, we will be granting de facto recognition to the concept of two-tiers of medicine in America--one for the affluent and one for the poor. That concept may reflect long standing realities, but it has never been acceptable as a statement of the ideal, nor have we ever explicitly legitimized it. I do not believe we should do so now.

It is not so much the fact that we are developing a two-track system of health care delivery that is troublesome. It is conceivable that this nation could provide adequate, quality care for both populations, even though one group is served by different providers from the other. But a two-tier approach to health care can also create medical ghettoes, where benign neglect permits quality to slip, facilities to deteriorate, and patients to suffer. That is the danger we must guard against as county hospitals take on ever greater responsibilities for providing health care for the poor.

This is more than a hypothetical concern. At this juncture, we must ask whether or not the communities across America are prepared to deal with the swelling numbers of persons who need medical care but cannot pay for it? The answer is that we will do as much as we can, but miracles are far more common in modern medicine than they are in government finance.

To make ends meet in health care, as well as other areas, counties have had to be highly creative. We have contracted out services, lengthened repair cycles, deferred new construction, eliminated services, raised fees, borrowed against endowments, and moved aggressively toward health care cost containment strategies that emphasize community-based and home care. Many counties are investing heavily in preventive health, prenatal care, and teen-pregnancy programs to reduce future costs. We are experimenting with capitated HMO plans, health care vouchers, and other innovations. But like the refrain from "Oklahoma," we've gone about as far as we can go. Far too many of our hospitals need refurbishing, remodeling, or replacement. Too many of our interns are called upon to work long hours because of staffing shortages. And our taxpayers are questioning the excessive costs associated with operating outmoded facilities. Even though we have benefited in many ways from the belt-tightening, we have no magic answers and fewer and fewer alternatives to enable us to carry on under constantly worsening conditions.

There is a saying that, when life hands you a lemon, you make lemonade. Well, Mr. Chairman, today there's a lemonade stand on every county courthouse lawn in America. We've squeezed the juice from the bitter fruit of Federal cutbacks. We've ground the pulp and the seed and the skin to quench the thirst for essential health care for the poor of the nation. But when the pulp and the seed and the skin have yielded their last drop of relief, what then? There is simply a finite limit on the ability of counties to meet the need.

Counties rely upon the property tax for their major source of local funds. It is a relatively inelastic revenue source, since, in most communities, property tax increases must be approved by taxpayers. Recent history suggests that voters are increasingly

reluctant to accept an additional property tax burden. Some recognize it as a regressive form of taxation. Others object because they are not the consumers of the services funded through the levies. The elderly, living on fixed incomes, view the property tax as a threat to their financial security and their ability to remain in their own homes. And, in 26 of our states, counties are constitutionally prohibited from raising the property tax rate above a specified millage. The property tax is not a "deep pocket" that can finance an inexhaustible demand. Places like Dade County, Florida, aleady ask the local taxpayer to foot the lion's share of public health care costs. Out of a $147 million health services budget, local revenues provide $122 million. In Guilford County, North Carolina, $8 million of the $11 million county health budget is derived from local sources. If you are seeking a way to fund health care, the property tax is not the answer. It may be an element in the equation, but it cannot be the foundation on which to build a stable, equitable, or sufficient system of financing health care in America.

The problem of indigent health care may find its expression at the local level, but it is not fundamentally a local problem. It is a national problem. Indigents can, and do, move freely across local jurisdictional lines. Some gravitate to particular regions because needed services are more readily available to them. Homeless persons, illegal aliens, the unemployed and individuals who have fallen through the cracks of deinstitutionalization tend to congregate in urban areas. Places without health care facilities may "export" their indigent care problem to jurisdictions with public hospitals.

A case in point is Shelby County, Tennessee. Shelby County has a fine public hospital that serves a large proportion of indigent patients. It sits astride the state line where Tennessee, Arkansas, and Mississippi come together. The counties which straddle the Mississippi to the south and the west of Shelby County do not have public facilities comparable to the Memphis area. The result is that Shelby County ends up providing uncompensated care for persons from the surrounding tri-state area. By and large, Shelby County taxpayers pick up the tab. And similar situations prevail wherever a hospital catchment area crosses county or state lines.

President Truman used to have a sign on his desk in the Oval Office. It said, quite simply, "The Buck stops here." I wish that were true today when it comes to indigent health care. But the reality is that, in a form of perverse "trickle down" theory, the Federal government has passed the buck to the states, and the states have passed it to the counties. Now that sign could hang in any county hospital waiting room in America, for that's where "the buck" truly stops.

The National Association of Counties believes in our Federal system of government, in which each level of government does what it is best equipped to do, coordinating and cooperating with the other levels for the common good. For us, that implies that counties have a role in the delivery of services for the indigent, but that the entire burden should be shared equitably with the Federal and state levels of government. Reliant as we are upon the property tax base, the financing of health care is not what we can do best.

In rural America, farm property values are dropping as more and more families are forced into bankruptcy. The downward adjustment of assessed valuations erodes the property tax base a county depends upon for revenues. Yet the displaced families may need health care services they cannot pay for, increasing the uncompensated care burden carried by a county. The same catch-22 situation may prevail in counties impacted by plant closures or other economic dislocations. It makes little sense to ask a county in a distressed region of the country to expand its health care services to take in former taxpayers who are unemployed, homeless, and without means, and to fund those expanded services from revenues obtained from a shrinking tax base. Those counties least able to afford it should not be the ones asked to do the most.

What counties do best is to manage and deliver health care services. But they must have adequate resources to do this. The Federal government, as a full-fledged partner in the effort to resolve the problem of indigent health care, must accept its legitimate role as the focal point for collecting and allocating resources to assure every American equal access to decent and affordable health care.

If our county hospitals are to survive as an integral part of our health care system, if they are to continue to fill a need not being met elsewhere, we have to work together to find a better means of financing their operation.

I come from Monterey County, the home of Cannery Row. And so I am familiar with John Steinbeck's portrait of the United States during the Great Depression. In his writings, I can hear the echoing pleas of impoverished mothers seeking comfort for their ill children, husbands looking for a healing hand to lay upon the fevered brow of their spouses, the sick and the poor longing for relief. But that was then and this is now and it is inexcusable for the strains of that Depression-era litany to still resonate across America. Yet in the county hospitals of our land, a bleak reality reminds us of the unfulfilled promise of universal health care to those in need.

I am pleased to join with the National Association of Counties in endorsing your continuing effort to bring that promise to fruition. We stand ready to work with you in developing practical solutions based upon a strengthened partnership committed to our common goal of accessible and affordable health care for all Americans.

Chairman STARK. Thank you very much.

Mr. Moody?

Mr. MOODY. Well, it seems like very good testimony. You have a different statement than this one, I guess, do you not?

Ms. SHIPNUCK. I was just summarizing some of the parts of the statement, because I knew the time would not allow me to read seven pages.

Mr. MOODY. Right. I was looking for your reference to Milwaukee County. How much, $27 million?

Ms. SHIPNUCK. $27.1 million a year.

Mr. MOODY. Thanks. I have no specific questions, but it was very helpful.

Mr. SHIPNUCK. Mr. Moody, would you mind if I just commented on a question you asked previously?

Mr. MOODY. Sure.

Ms. SHIPNUCK. The question you asked Mr. Allison about why citizens of Wisconsin through their Federal taxes should subsidize medical indigent care in Texas, and the assumption that——

Mr. MOODY. Because we are already doing it, to some extent, for ourselves.

Ms. SHIPNUCK. I understand, and the assumption that anybody in a Texas hospital is a Texan. I think we need to look at what is happening across the country, and particularly in that example, and one of the populations that the Federal Government has conveniently washed its hands of, the undocumented aliens.

You have border States, California, Texas, Florida, that are absorbing an enormous cost of providing care for these individuals, some of whom are likely on their way to urban center jobs in the Midwest or other parts of the country. They subsidize the economy of the entire country, whether they work in agriculture or in factories. And there are other populations like that, whether they are the homeless that aggregate in certain Sun Belt areas of the country, or the chronically mentally ill, who we cannot target and find in certain areas.

And I do not think that you can say that it is only a local problem or only a specific state problem. I do recognize your concern about dollars being shifted, but I also recognize and can give some examples of certain target populations in Monterey County where we have paid 100 percent county dollars for people who are not county residents, and who we would otherwise not have to fund at all.

Mr. MOODY. Yes. Attaching locations to people is always a tricky thing to do, because we have such a mobile population. I would say that a high fraction of our indigent care patients in Milwaukee are people who were born in the South and have come to Milwaukee undereducated, undertrained, and under-invested-in by other States.

We tax ourselves very highly to take care of those people.

Ms. SHIPNUCK. We do, too, in California, so——

Mr. MOODY. I think I particularly want to make the point that Mr. Allison is represented by a Senator who is railing against our spending money to do exactly what he is asking us here to do.

Ms. SHIPNUCK. I understand that, and that is why I so much appreciate this committee looking at this issue, because it is a very real issue that does involve substantial dollars.

Chairman STARK. How do we get Orange County to do what Monterey County and Alameda County do?

Ms. SHIPNUCK. I knew you were going to ask that one.

Chairman STARK. I do not know. You are the county supervisor, and you all are doing the right thing. Somehow Orange County slipped out. I do not suppose there is a Federal solution to that. It sounds to me more like the state has to do something.

Ms. SHIPNUCK. I do not think we can ever tell every county across the country that they have to meet the same level of care and concern as a particular Wisconsin county or a particular California county, or other examples that we want to hold up. Perhaps the issue is some way of providing incentives for counties to do more rather than the attempt to penalize those counties that are doing less, which then, of course, tends to backfire as money drains out of our budgets.

The situation of Orange County, I think, as presented by Dr. Rucker, was a little oversimplified, because the university did want to buy the county hospital, and in doing so basically relieved the county of the responsibility for running that facility, and Orange County then contracted out their medical indigent care, including to the university facility, and the university did not want to subsidize their own facility to the extent that the county previously had.

The university, on the other hand, as a university facility was one of only four facilities in the State of California last year that are publicly owned that received State money for upgrading their plant.

So I think we need to look at the entire issue in terms of how money flows in and what the responsibilities are. Monterey County has chosen to maintain a county hospital. Health care is a major issue in our county. It is one our board is very committed to, but we do that at a tremendous cost. And by putting $5 million in the county hospital, there are county roads that are going unpaved, there are other services that we are not providing. We have made that choice. Other constituencies, other jurisdictions, sometimes make other choices; just as Mr. Moody was pointing out, some Senators and some Congressmen make different choices. Not everybody responds the same way to the same issue.

But I would again stress we think that the Federal role is helping augment us in doing what our constituencies want us to do, and most constituencies do want local government in the health care business.

Chairman STARK. Thanks very much.

Mr. LEVIN. Mr. Chairman, this——

Chairman STARK. I am sorry.

Just as you leave, does NACo have a specific position on how to resolve the budget crunch here in Washington?

Ms. SHIPNUCK. NACo's primary position has always been that the cuts need to be across the board; that no one part of the budget should be spared; and that there should be an equivalent amount of cuts on the defense side as there are on the domestic program side.

And what we see is a disproportionate cut on the domestic program side as opposed to the defense side.

Mr. LEVIN. How about on the issue of whether there should be new revenue?

Ms. SHIPNUCK. We have looked at certain taxes that we have indicated we would support, specifically what we commonly call the sin taxes. NACo is on record as supporting those. And we have not taken official positions on any of the other tax measures.

Chairman STARK. Do you have any reading material from Napa, Sonoma, and Monterey Counties on those?

Ms. SHIPNUCK. I am sorry?

Chairman STARK. I was wondering how Napa, Sonoma, and Monterey Counties felt about excise taxes on wine.

Ms. SHIPNUCK. I would support it, and I am from Monterey County——

Chairman STARK. I know.

Ms. SHIPNUCK [continuing]. And I think our constituency would as well.

Mr. MOODY. Wait, I thought we were talking about a tax on sin, beer, and bratwurst. I did not know that wine was sin.

Chairman STARK. I thank the witness.

Ms. SHIPNUCK. Thank you.

Chairman STARK. Barbara, thanks very much.

Our tradition is to save as much of the best as we can for last. We will call on Jack Owen, the executive vice president of the American Hospital Association.

Jack, welcome back. Your testimony will be made part of the record, and proceed in any manner you are comfortable.

STATEMENT OF JACK OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. OWEN. Thank you, Mr. Chairman.

I am Jack Owen, executive vice president of the American Hospital Association and director of the Washington office.

Since my testimony is part of the record, and the hour is getting late, and you have heard all kinds of reports on what it is like, from the first panel, of living in hospitals with these problems, I would like to just cover a few points that, as you consider legislation of this kind, you might keep in mind.

I think there is no question, as you learned this morning from the panel first on the agenda, that the new system of competition and prospective pricing system has done a lot to cut back on the cost of health care, but the Achilles heel of this whole competitive system is who pays for the poor. No one wants to compete in the inner city or in the rural area where no one is paying their share of the cost of indigents. And that is one of the big problems we are facing.

It was interesting to note as you were asking some questions, Mr. Chairman, about county hospitals, there are a lot of States in our country who do not have county hospitals. Having spent 19 years in New Jersy, we had one county acute hospital in the whole State of New Jersey. So——

Chairman STARK. Did you have other community—I mean, publicly maintained hospitals?

Mr. OWEN. Only a city hospital, Jersey City and Newark each had a city hospital, but other than that, Bergen County was the only county hospital. The rest of the State, the voluntary nonprofits were expected to take care of those people.

Chairman STARK. What do you ascribe that to? A religious heritage.

Mr. OWEN. God would have said——

Chairman STARK. No, seriously, do you have a——

Mr. OWEN. Actually, there was a lot of Catholic hospitals and——

Chairman STARK. A lot of—that is what I say, how do the Catholic charitable——

Mr. OWEN [continuing]. Religion probably had a lot to do with it, that is correct.

Chairman STARK. Well, there is Louisiana, I gather, where the State has a system——

Mr. OWEN. Yes, that is correct.

Chairman STARK [continuing]. Of charity hospitals.

Mr. OWEN. Yes, a big one in New Orleans, that is right.

Chairman STARK. Well, they cover the whole State. The State government funds a string of hospitals.

Mr. OWEN. That is right, and there was one, Kentucky, I think had some miners' hospitals which were funded across Appalachia. But we find that there an awful lot of places in the country where there just are not that kind of government participation, and the nonprofit or the voluntary hospitals are responsible for taking care of these people.

I think——

Chairman STARK. That may go the way of doctors providing charity service.

Mr. OWEN. Well, the charity that the doctors provide in most cases was done in clinics, really, in places that I am most familiar with, where they would spend a day or a morning a week in that clinic. Once they got into the hospital taking care of the patient, that was a different matter.

But I think, as the other panel reported, I think that once the government got into the business and health care became a right, then doctors expected to be paid, and I think that is something we are going to have to live with. I do not think we can expect free care from physicians to solve our problem. Its just not going to be there.

The hospital has been the safety net, and I think it was pointed out here earlier that if you are really in sad shape, if you are in an automobile accident or something like that, you are taken care of. But the problem that we all know is the patient that does not need to go to the hospital right today.

Chairman STARK. I cannot resist suggesting that if the physician spent as much on indigent care as they spend on political campaigns and did it better, we would be much better off.

Mr. OWEN. I have nothing to comment on that, because that is not my organization.

I would just like to make a couple of comments. Until we come up with some long-term solution, and I think your access bill last year was a start toward that longer range solution, and one that we supported, that has got to be the way we cover some of these people with insurance. But until we get to that we are going to have some hospitals, I am afraid, that are going to go bankrupt in places where we cannot afford to have them go bankrupt.

We heard Ms. Brown talk about the problems they had down in Mississippi, and Jim Mongan in Kansas City. And it seems to me that if we could find some solution to take care of the problem hospitals while we try to work out the long-range answer, it would be an ideal solution.

And it seems to me that there is a couple ways we could look at this, and we are more than willing to work with you in trying to determine what these hospitals might be. But if we looked at the high ratio of unsponsored care to private pay patients, and also looked at the deficit, the negative margin between patient revenue and patient expenses, we could start to identify some of these hospitals. No matter how you cut it, and I think you have said it many times here publicly, that somebody has to pay the bill. Somebody has been paying the bill, but there has been a shift over the years from the private pay patient.

What has happened in this new competitive model, as you so well know, is no one wants to pay for anything other than the patients that they are responsible for, including Medicare and HMOs and PPOs and Blue Cross and a lot of others. So we have no shifting of costs taking place.

At the same time, because of the recent recession and the problem of companies limiting payment for health care premiums, we are seeing more and more people are not covered, the number of working people who are not insured continued to grow. We are getting a large number of people admitted, and no way to shift costs. We have got to somehow develop a program that will help those hospitals who are caught in that kind of a situation.

I think there is a formula that could be adopted. You heard from a panel member that Florida has a formula we think it could be worked out nationally. We have some problems right now and are working on how to determine what is a private pay patient.

Chairman STARK. Do we not have to know, and Mr. Moody touched on this a little bit, what different counties are doing? If we are going to provide Federal funds somehow to take care of the indigent and/or charitable or bad debt problem, do we not have to demand some kind of Federal standards from the community.

In other words, is it fair for us to say, we are going to pick up the tab, but why should we pick it up as much in Orange County, where perhaps the county is not contributing as much, as Monterey County, or Monterey—let us assume Monterey and Milwaukee County are the same size—Milwaukee County is kicking in $27 million and Monterey is kicking in $5 million. Should there not be some standard of what the community or the state provides?

When States make it tougher to get on Medicaid, they are basically cutting down on their response, their financial responsibility, for poor folks. And in a different committee in different times, we have tried to set Federal standards for qualification for transfer

payments, and, of course, that raises a political hornet's nest that is really tough.

Should we not be able to expect a uniform level of community contribution to this effort as a requirement for the federal contribution?

Mr. OWEN. I would have no problem with that. I do not know whether it should be uniform or whether it might be a floor.

Chairman STARK. Well, say a federal minimum.

Mr. OWEN. Yes, but at the same time it would seem also that there ought to be a definition of benefits and eligibility some federal guidelines, so that we did not have somebody in one state that was eligible and in another state not eligible, because that is——

Chairman STARK. Well, then you must provide it. Suppose you are in a disproportionate share area, so you get 10 percent added onto your DRGs. The back side of that is they are not taking any poor people in. They must provide the care to get the 10 percent, and if the 10 percent is not enough, then the county has to contribute something toward it.

We may not fill all the gaps perfectly, but I am saying there is a partnership, and all the partners should pay.

Mr. OWEN. I think that is absolutely right. I do not think it is solely a Federal responsibility. It is a state, and it is a county, and it is a hospital responsibility.

Chairman STARK. Okay, what I am trying to get you to tell me is that we ought to set the standards at the Federal level, the minimum standards——

Mr. OWEN. I understand what you are——

Chairman STARK [continuing]. And then let the States add to it, not——

Mr. OWEN. Yes.

Chairman STARK [continuing]. Set some hoped-for standard and let the States opt out, as was done when we split Medicare and Medicaid.

Mr. OWEN. Well, that is right. We started that way, really, with Medicaid at one point, and if you go back a little bit, like I do, to the Kerr-Mills program, where no standards were set, and where it all really fell apart was because there were no standards, each State had its own program under Kerr-Mills, and those who had some money did something, and those who did not did nothing.

No, I do not disagree with that as an approach, and I also feel that it is a responsibility that goes beyond the Federal Government. There is a State, county, and hospital responsibility for taking care of some poor.

And I guess, just to conclude, I would say that we stand ready to work with you, give you whatever data we can and to try and identify those hospitals who are really in trouble right now, and that is the main thing we are——

Chairman STARK. What data do we need? You know, we get gamed by OMB, who hide data from us. Particularly data that will cause money to be spent they do not want to get spent, so they sit on stuff up there till it hatches. HCFA has to play that game with us, and I suspect we are playing the same game with our own Budget Committees, and hospitals want to only submit favorable

data and they do not want obviously, to be burdened with a lot of recordkeeping.

Have you guys ever come up with kind of a standard accounting system that we could require and where you would collect the data and just limit the access to it to protect privacy, if that is necessary. Because it just seems to me we would get a whole hell of a lot further down toward solving this problem if we knew what we were dealing with.

Mr. OWEN. Well, we do not have a standard accounting system, we have a standard reporting system which is helpful in——

Chairman STARK. It does not do income.

Mr. OWEN. What is that? Oh, yes, it does.

Chairman STARK. Well, it does not to us. What we are getting at HCFA does not.

Mr. OWEN. No, no, we have income, and that is what I am really saying, that you got to take—look at the——

Chairman STARK. Well, you are not at liberty to share that with me?

Mr. OWEN. Well, I think, as you know, the last time we talked about it——

Chairman STARK. You did. I mean, I want to thank you for that. I understand your——

Mr. OWEN. Yes, but it is not quite as easy as it sounds, because we do have to get permission from the hospitals to share it.

Chairman STARK. You cannot put your members in jail if they cheat on that because it's not your form.

Mr. OWEN. That is correct. But we will be happy to share with you, and I am sure that most of the hospitals who are in the situation of having a problem will be more than willing to share it as well, so that I do not think it will be a problem getting the information.

Chairman STARK. Does ProPAC have as much data as you do?

Mr. OWEN. No, they use our data quite a bit. We provide that to them.

Chairman STARK. What kind of huge political problem would there be if we just mandated that? Every hospital in the country belongs to Medicare, right? So we have the Federal hook on them now. What if we just said, take what they are filling out for you anyway. No sense my redesigning the form, I would not know what to ask for. And just say, look, you got it, now it becomes a Federal law, that data must be in in timely fashion. You are going to get it anyway. We will give you a copy of it and save you all that postage. We will give one to ProPAC and one to HCFA. And then it is there.

Would your membership fight and scream.

Mr. OWEN. Well, I think some of them would, some of those who feel that that would maybe hamper their competitiveness and their bidding on PPO contracts or HMOs. That is what they tell me.

I would say that 90 percent of the——

Chairman STARK. They do not say that about income tax——

Mr. OWEN. No, I——

Chairman STARK. If those who are making a profit could be kept quite confidential.

Mr. OWEN. I do not think it is as much of a problem getting the information, there would be some hospitals, and we probably could identify those, would not. But I would guess that the majority of the nonprofit hospitals would be more than willing to share their data, and it is in many of the States like New Jersey, public information.

Chairman STARK. Is your data as complete as what HCFA gets?

Mr. OWEN. Well, it is probably more complete, because HCFA is only concerned with Medicare, where we are looking at the total patient population.

Chairman STARK. Well, I do not know. I might just find that the data does not do anything. I would not understand it if I saw it.

Mr. OWEN. Well, I think what we are interested in—I think you are, too, is that this bill, as I understand it, is going to help those hospitals that are really distressed. It is not going to solve the problems of all indigents at the start.

Chairman STARK. No, but we do it with such a slapdash approach. If you have got a fairly current data base and a way to collect this today with computers, the feedback ought to be fairly quick. What do they say if we just cover the disproportionate share, or some percentage of it? Then we would at least know it is going out fairly, and we do not have to have days of testimony with the rural guys shooting at the urban guys, and the southerners screaming about the northerners, and vice versa.

It seems so silly to me for us to be arguing about numbers that exist. If we knew what the numbers were, we could save all this conjecture.

Mr. OWEN. Right, we could——

Chairman STARK. You would not have to listen to me make so many speeches.

Mr. OWEN. We might even end up with a blended DRG rate, might we not?

Chairman STARK. We might be better overall. I sure think that adequate data might let us solve the problems. They are difficult enough without having adequate data. At least then we are not guessing.

Jack, thank you again for your contribution and your unceasing efforts to help us make this process work a little better.

Mr. OWEN. Thank you.

[Statement of Mr. Owen follows:]

STATEMENT OF THE
AMERICAN HOSPITAL ASSOCIATION

INTRODUCTION

Mr. Chairman, I am Jack Owen, executive vice president of the American Hospital Association (AHA) and director of the Washington Office. On behalf of our 5,600 institutional members, we welcome this opportunity to testify before the Subcommittee on Health of the House Ways and Means Committee on the subject of hospital indigent care. Indigent care has been called the Achilles' heel of the competition model of health care, and for good reason. Increased competition in the health care industry and increased cost containment efforts in the public and private sectors have led both to a growing indigent care problem and to a disruption of traditional ways for financing it. A competition model lacking some sort of safety net for the poor uninsured and underinsured inevitably will lead to a decline in access to care. For this reason, we are pleased that this subcommittee is considering federal support for hospitals in financial distress because of their continuing commitment to patients who cannot pay, and we appreciate your invitation to offer suggestions on how such a program might be devised.

In the last decade, Medicaid coverage of the poor has shrunk from 65 percent to 38 percent. This has happened because the number of people below the federal poverty level has grown, while the number of Medicaid recipients has declined. Moreover, state and local medical indigence programs have taken up little of the slack. As a result, 37 million people--mostly poor or near-poor--are uninsured and therefore at significant risk of requiring medical services for which they cannot pay.

For these 37 million Americans and an additional 20 million "underinsured" Americans, local hospitals--not government--have had to create the medical care safety net. It is not likely that they can continue to do so, unaided, in an increasingly competitive system. In 1985, uncompensated care cost hospitals $7.4 billion, up from $3.5 billion in 1980. Although local tax appropriations to hospitals were able to cover some of this, $6.3 billion in 1985 medical care costs were truly "unsponsored" and therefore had to be absorbed by hospitals or passed on to other patients in the form of higher charges.

Traditionally, hospitals have been able to subsidize the cost of care provided to the medically indigent by increasing charges to privately insured patients and to patients able to pay their own bills, but the ability of hospitals to do this has declined sharply. The principal sources of government financing, Medicare and Medicaid, provide no subsidies for costs incurred by indigent non-beneficiaries and, in a competitive environment, private payers increasingly are seeking to negotiate similar arrangements. Hospitals which continue to provide large amounts of unsponsored care are at a competitive disadvantage in an increasingly price-driven payment environment.

What makes this a public policy problem rather than an individual hospital problem is that the distribution of unsponsored care is extremely uneven, and high volume providers already are under considerable financial stress because of their service to the poor. Without some change in this configuration of forces, many of the hospitals currently providing large volumes of unsponsored care will be forced to choose between bankruptcy and a drastic reduction in service to the poor. Particularly in the case of sole community providers, either choice could severely restrict access to care.

In February 1986, the AHA Board's Special Committee on Care for the Indigent completed its report, Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent, which outlines a series of long- and short-term public and private initiatives that could be adopted to avert this crisis. An enduring solution to the problem of medical indigence will require initiatives by both private and public sectors to reduce the size of the medically indigent population through adequate private health insurance, and to restructure and extend Medicaid so that it does a better job of covering those who cannot obtain private insurance. This public insurance component will require a broadly based and stable financing mechanism such as a payroll tax.

In the short term, the issue should be dealt with through a series of incremental steps that strengthen incentives to provide employer-paid health

insurance and which gradually strengthen public programs. Some of these incremental steps were included in the Health Care Improved Access Act that Congressman Stark introduced, and we supported, last year. In general, increasing public and private insurance options through measures such as these makes more sense than providing direct grants to hospitals because people with insurance are more likely to seek and receive necessary care in a timely fashion and in an appropriate setting. Insurance also provides a better mechanism for allowing consumer choice and encouraging cost effective care, for example, through case management and utilization controls.

While these short- and long-term measures to strengthen private and public insurance are being drafted, debated, and implemented, however, we need to deal with the immediate problem of providing a safety net for the poor uninsured and hospitals that serve them. As a matter of principle, no hospital should be forced to close because it serves the poor, and nobody should be denied necessary care simply because of inability to pay. Therefore, we welcome the subcommittee's invitation to testify on how one might devise a program to identify those hospitals which are in danger of closing because of their service to the medically indigent.

PROPOSAL TO PROVIDE RELIEF FOR HOSPITALS SERVING THE POOR

We understand that the subcommittee is interested in developing a program to provide federal support for hospitals in financial distress because of their continued commitment to patients who cannot pay. Several issues arise in designing a program of this sort. Most important, it is imperative that any formula used to identify target hospitals be fair, workable, and to the point. It should target all hospitals that are financially stressed because of service to the poor and exclude those institutions that are financially stressed for other reasons or able to serve the poor without experiencing financial stress.

Identification of Target Hospitals

Hospitals "at risk" share three characteristics:

- A high volume of unsponsored care;
- A small private-pay base over which unsponsored care costs can be spread; and
- A deficit in patient operating margins.

In one form or another, all three of these variables should be included in any formula designed to identify those hospitals most in need of additional support. One simple way to do this might be to devise two tests hospitals must pass in order to qualify:

- A high ratio of unsponsored care costs to private pay patient costs; and
- A negative patient operating margin.

To receive support, hospitals would have to meet both conditions. In preparing a formula of this sort, it is important to establish a clear concept of the major variables used, then develop precise definitions and appropriate indicators for each. Following is a discussion of what the terms "unsponsored care," "private pay revenues" and "patient operating margins" mean, why they are the best variables for identifying hospitals experiencing financial stress because of service to the poor, and how the three variables might best be measured and combined into a formula.

There are at least three ways to express figures on "free" care provided by hospitals:

- Uncompensated care charges: The total amount of bad debt and charity care, i.e., the difference between charges and payment attributable to bad debt and charity care. In 1985, uncompensated care charges totaled $9.5 billion nationally, according to AHA survey data.

- Uncompensated care costs: The total cost of bad debt and charity care, i.e., the difference between payments and costs, usually calculated by multiplying uncompensated care charge data by the cost-to-charge ratio. Cost and Compassion, the report of AHA's Special Committee on Care for the Indigent, uses these lower, cost-based figures. AHA data show $7.4 billion in uncompensated care costs for 1985.

- Unsponsored care costs: Uncompensated care costs minus state and local governmental tax appropriations, i.e., the net amount absorbed by the hospital or shifted to private payers. In 1985, AHA estimates, state and local tax appropriations were $1.1 billion, leaving $6.3 billion in unsponsored care to be subsidized by the private sector.

All three definitions include both bad debt and charity care, but do not include Medicaid underpayment costs or other contractual allowances.

In theory, bad debt is defined as care for which an individual could have paid but did not, while charity care is defined as care for which a hospital decides not to collect payment because of the patient's inability to pay. In practice, however, almost all uncompensated or unsponsored care goes to people with very limited resources, so the distinction between charity care and bad debt largely becomes a matter of traditional accounting practices and community expectations. Recent studies of medical indigence in Florida and South Carolina, for example, found that about 90 percent of the uncompensated care was attributable to people who were poor, near-poor, or uninsured.

Far more significant than the bad debt-charity care distinction is the difference between uncompensated and unsponsored care. Unsponsored care figures provide a better measure of a hospital's burden in caring for the poor, because they are "net" of government appropriations, and therefore indicate the cost that must either be absorbed by the hospital or passed on to private-pay patients. In 1985, for example, uncompensated care costs were $7.4 billion, but local government grants and appropriations to some hospitals covered $1.1 billion of this, leaving $6.3 billion in unsponsored care costs. Receiving some government support reduces problems of publicly supported hospitals, but a large gap between the subsidy amount and the cost of care leaves many public as well as private hospitals with a sizable unsponsored care burden. In a competitive market dominated by a few private insurers and public programs that do not recognize or participate in the cost of unsponsored care, the survival of public or private hospitals providing high volumes of unsponsored care is likely to be in jeopardy.

The distribution of unsponsored care across hospitals is extremely uneven. In 1984, 5 percent of all hospitals accounted for 22 percent of all hospital expenses but provided 36.7 percent of all unsponsored care. Several factors are responsible for this, including the mission and the environment of the hospital. Care of the indigent is the major mission of most public hospitals and many voluntary hospitals, and these hospitals provide substantially more unsponsored care, other things being equal, than hospitals whose missions emphasize other aspects of community service. Particularly if they are sole community providers, hospitals in areas with a large medically indigent population will obviously have a large volume of unsponsored care.

In 1984, about 1,400 hospitals provided unsponsored care exceeding 5.6 percent of their costs, and of these almost 300 provided unsponsored care totaling more than 10.3 percent of their costs. If an unsponsored care level of at least 10.3 percent of costs were established as a cut-off for hospital "safety net" funds, therefore, 289 hospitals would fulfill this requirement.

Although it would be relatively easy to estimate how many hospitals might qualify if a cut-off were set--for example, at 7 percent of total costs--using any fixed cut-off figure could lead to an inappropriate targeting of safety-net funds. Unsponsored care percentages do not reflect differences in a hospital's ability to support such care. Unsponsored care levels of 6 percent might be very difficult for some hospitals to maintain and relativelyeasy for others. For example, in states with high Medicaid eligibility levels but low Medicaid payment levels, a hospital with very little unsponsored care but a large number of Medicaid patients may still be

allocating a sizable proportion of its costs to the provision of care for the medically indigent.

In short, hospitals with large unsponsored care burdens cannot withstand a payer mix with few private pay patients, and particularly cannot withstand a high-volume, undercompensated Medicaid load. High Medicare patient volumes and payment shortfalls associated with inequities in the Medicare payment system also can create substantial problems in serving the poor. For hospitals with an unfavorable payer mix, even moderate levels of unsponsored care could be devastating.

One way to try to account for these differences in payer mix is to compare unsponsored care costs to private pay revenues. Unsponsored care is an implicit or "shadow" tax on private payers. If a hospital has few charge paying patients, even a small unsponsored care volume can be difficult to support. For example, if a hospital has an unsponsored care level of 5 percent and derives only 50 percent of its revenues from charge paying patients, it must raise its charges to a level 10 percent above costs just to break even. If only 25 percent of the hospital's revenues are derived from charge paying patients, its charges must be set at a level 20 percent above costs to break even. On the other hand, a hospital that derives a large portion of its revenues from private payers will be able to afford higher unsponsored care levels without raising charges to uncompetitive levels. Viewed from this competitive perspective, it is apparent that the major policy questions do not concern simply the variations in unsponsored care volumes among hospitals, but rather the joint variation of unsponsored care volume and the ability of hospitals to subsidize unsponsored care through charges to private patients.

For these reasons, we recommend that the unsponsored care and private pay variables be combined into a single qualifying screen, expressed as a ratio of unsponsored care costs to private pay patient costs. This approach poses some problems, however, that will require further work. Chief among them is deciding how to define private pay patient costs.

For example, some Blue Cross/Blue Shield plans pay charge-based rates. Others, however, pay only costs and therefore do not include any explicit or implicit subsidy for indigent care. Should Blue Cross/Blue Shield revenues be counted as private pay? Perhaps private-pay revenues should be defined as those which are derived from charges. This definition would include Blue Cross/Blue Shield revenues under some plans, but not under others. A more difficult problem would be accounting for differences in discounting from one hospital to another. In competitive areas, where heavy discounting occurs, many private-pay patients may, in fact, not be part of the base over which unsponsored care costs can be spread. In such areas, hospitals forced to accept heavily discounted rates from HMOs or PPOs, for example, might have a larger private pay base but still be experiencing financial distress and have difficulty supporting their unsponsored care load.

The second criterion for establishing eligibility for safety-net funds should be financial stress. Financial stress could be defined in many ways. One study, for example, identifies six different ratios that might be used as indicators of financial stress: return to assets ratios, operating margin ratios, debt ratios, cash flow to debt ratios, cumulative depreciation ratios, and current asset/liability ratios. For the subcommittee's purposes, however, the most logical and straightforward measure would be patient operating margins, because this measure indicates whether hospitals are able to generate sufficient revenue from patient care to cover their essential functions.

Data from AHA's 1984 Annual Survey of Hospitals show that more than half of all hospitals experienced patient operating losses during 1984, and more than one-fifth experienced losses of 6 percent or more. Specifically, 19 percent had deficits between 0 and 3 percent, 11.9 percent had deficits between 3 percent and 6 percent, and 21.4 percent had deficits more than 6 percent.

Though half of hospitals are experiencing losses, most of these losses are attributable to factors (competitive pressures, declining admissions, changing demographics) other than care to the poor. Hospitals that are facing deficits and have a high unsponsored care/private pay revenue ratio clearly are in jeopardy because of their decision to care for the poor, and these are hospitals that should be helped by this sort of limited purpose program.

Additional Issues

Several other additional issues should be addressed in devising a safety net formula.

First, any single national formula may be too rigid to accomplish the subcommittee's goals of assuring the survival of hospitals that the poor depend upon. If a hospital is a sole community provider, for example, its continued viability is crucial to access by the poor and non-poor alike. For this reason, the subcommittee might want to set more "lenient" standards for such providers.

Second, it might be appropriate to require that applicant hospitals make available records, for example, on bad-debt collection efforts and charity care determination procedures as long as these requirements are reasonable and not burdensome.

Finally, the subcommittee might wish to consider some sort of "maintenance of effort" requirement for state and local government; otherwise, some state or local governments might see the federal safety net payment as an opportunity for reducing local grants and appropriations to hospitals.

CONCLUSION

We are pleased that this subcommittee is considering federal support for hospitals in financial distress because of their continuing commitment to patients who cannot pay, and we appreciate your invitation to offer suggestions on how such a program might be devised. Clearly, nobody should be denied necessary care simply because of inability to pay, and no hospital should be forced to close because it serves the poor.

We believe that a method for workable, fair identification of eligible hospitals can be devised. As a starting point for discussion, we suggest two tests hospitals should meet to receive assistance:

- A high ratio of unsponsored care costs to private pay patient costs; and
- A negative patient operating margin.

Designing these two tests will require further work and analysis. The definition of private pay patient costs must be sensitive enough to account for differences in market-driven discounting. In competitive areas, where hospitals are forced to accept heavily discounted rates from HMOs or PPOs, for example, hospitals might have a larger private pay patient base but still be experiencing financial distress and have difficulty supporting their unsponsored care load. Designing a program of this sort also will require some policy decisions.

Determining what ratio should serve as the cut-off for funds and what level of support might be available for hospitals with varying ratios will be a policy decision requiring careful data analysis. It is important that a program of this sort target all hospitals--but only those hospitals--which are financially stressed because of service to the poor. We would welcome the opportunity to work together with the subcommittee in analyzing the data and refining the formula.

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Chairman STARK. The subcommittee is adjourned.
[Whereupon, at 12:12 p.m., the hearing was adjourned.]
[Submissions for the record follow:]

STATEMENT OF MARCELLUS GRACE, PH.D., DEAN, XAVIER UNIVERSITY OF LOUISIANA COLLEGE OF PHARMACY, AND PRESIDENT, ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to offer our comments on hospital care for our nation's indigent persons. The Association of Minority Health Professions Schools is deeply concerned with the problem of inadequate or, in many cases, inaccessible health care for our nation's poor and minority citizens. We believe that many Americans are unaware of the vast dimensions of this problem. To us, there seems to be no other explanation for why so many citizens who have so much to contribute to our society, should be living their lives without adequate medical care.

Amongst us, each institution has first-hand knowledge of the desperate national situation that exists in this country's ability and willingness to provide access to basic health services for the nation's many, many poor and minority citizens and families who reside in medically under-served inner-city and rural areas. Many hospitals are doing their best to provide this uncompensated care. However, the very hospitals providing these charitable services are finding themselves in severe financial trouble. Consequently, many hospitals are being forced to either cut back on the amount of uncompensated care they provide or close down. This is unfortunate. Many indigent persons are not receiving the medical treatment they need. It is also unfair that those hospitals, who took on the responsibility of providing this care, should suffer. These hospitals should not have to suffer because of the Federal Government's unwillingness to provide the resources needed to ensure that all Americans receive the medical treatment they require.

As the health status disparity between our nation's poor and minorities and the nation's majority population continues to grow, hospitals increasingly will be faced with financial hardship. At a 1986 National Conference on Health Care for the Poor held at Meharry Medical College in Tennessee, it was noted that there is a widening gap in health status among the nation's poor and minorities and the nation's majority population. Also, in August of 1985, a Task Force appointed by the Secretary of the Department of Health and Human Services reported a significant gap in health status among the nation's blacks and other minorities when compared to the nation's white population. Black infants are twice as likely to die in their first year of life than are white infants. The life expectancy of blacks is five years less than that of whites. The Secretary's Task Force reported that annually, in the black community, almost 60,000 excess deaths occur because of the disparity in health status. Evidence presented by both of these efforts also indicates that the problem is growing, not getting better.

Unfortunately, the Administration has consistently proposed to eliminate or severely cut a broad range of federal programs which provide assistance to the poor and minority populations of the country. Our nation's hospitals should not be asked to suffer the brunt of these cuts. The result will be financial ruin for many good hospitals. This is not cost-effective in the long run.

Mr. Chairman, thank you for the opportunity to present the views of the Association of Minority Health Professions Schools.

Statement

by

Deborah J. Chollet, Ph.D.
Senior Research Associate

The views expressed in this paper are solely those of the author. They should not be attributed to the officers, trustees, members, associates, contributors or subscribers of the Employee Benefit Research Institute, its staff or its Education and Research Fund.

Uninsured in the United States: The Nonelderly Population Without Health Insurance

In 1985, 17.4 percent of the civilian nonagricultural population under age 65 reported no health insurance coverage from any source. These people totalled more than 35 million in number. The proportion of the nonelderly population without health insurance has grown since 1982 (when 15.5 percent of the population were uninsured), and 1983 (when 16.5 percent were uninsured). The rate of noncoverage reported in 1985 was about equal to that reported in 1984.

Who are the uninsured?

In 1985, more than half of the uninsured (55 percent, or 19 million people) were workers. Another one-third (32 percent, or 11 million people) were children age 18 or under. Only 13 percent of the uninsured were nonworking adults, that is, people over age 18 who neither worked nor looked for work during 1985.

More than two-thirds (69 percent) of the uninsured population live in families of full-time, full-year workers (that is, people who worked or sought work 35 weeks or more and worked 35 hours or more in a typical week). For most of these people, the principal family earner (called the family head) experienced no unemployment in 1985. In all, 52 percent of the uninsured population in 1985 lived in families of full-time workers who were steadily employed throughout 1985. About 17 percent of the uninsured lived in families of full-time, full-year workers who experienced one week of unemployment or more during 1985, and another 17 percent lived in families of part-time or part-year workers. Fewer than 14 percent of the uninsured lived in nonworker families.

Over 64 percent of children who reported no health insurance coverage in 1985 lived in families headed by someone who was also uninsured. However, 29 percent of uninsured children lived in a family headed by someone with employer-based coverage. About two-thirds of those children--20 percent of all uninsured children--lived with an employer-covered worker who was either their parent or spouse.

The economic status of the uninsured population

Nearly two-thirds (63 percent) of the uninsured in 1985 lived in families with family income less than $20,000--approximately family median income in the United States. About half of these (35 percent of the total uninsured population) lived in families with annual family income less than $10,000. Of the 37 percent of the uninsured with family income above $20,000 in 1985, one third (12 percent of all uninsured) reported family income of $40,000 or more.

Tabulations of the uninsured by poverty status (based on family income and adjusted for family size) give a comparable picture. In 1985, 30 percent of the uninsured lived in families with below-poverty family income; 41 percent lived below 125 percent of poverty (that is, in poverty or near poverty). (In 1985, poverty income for a single, nonelderly person was $5,590; for a family of four, poverty income was $10,990.) More than half of all uninsured children who lived with an employer-insured family head (15 percent of all uninsured children) reported family income that exceeded 200 percent of poverty.

In 1985, 68 percent of all uninsured people lived in families with children. Just over half (34 percent of all uninsured) were in single-parent families. In all, 45 percent of uninsured children under age 18 lived in single-parent families (no spouse present); most of these children (37 percent of all uninsured children) lived in female-headed families. Among uninsured children in poverty, 50 percent were in families headed by women not living with a spouse. Nearly half of these (21 percent of uninsured children in poverty) lived with single women who were full-year workers.

Noncoverage among workers

More than three-quarters of all nonagricultural civilian workers in the United States (76 percent) reported coverage from an employer plan in 1985. Eighty percent of those (61 percent of all workers) had coverage from their own employer plan; the rest were covered as dependents of another worker. In 1985, 15 percent of all workers reported no coverage from an employer plan; most, but not all of the uninsured population are associated with these workers.

In 1985, three quarters of all uninsured workers earned less than $10,000. Nearly all (93 percent) earned less than $20,000. More than 35 percent of all uninsured workers earned, on average, less than the federal minimum wage in 1985; more than half of uninsured workers (50.4 percent) earned less than 125 percent of the minimum wage.

Relatively low earnings among noncovered workers are not necessarily related to part-time or part-year work. Among full-time full-year workers, 69 percent of the uninsured earned less than $10,000; and 92 percent earned less than $20,000. About one third of all full-time full-year workers earning less than $10,000 are uninsured.

More than half of all uninsured workers in 1985 were employed in two industries: retail trade (24 percent) and services (28 percent). Even among service industries which presumably employ relatively many skilled workers--professional services--noncoverage is common. In 1985, 9.8 percent of workers employed in professional and related services were uninsured; these workers represent 12 percent of all uninsured workers nationwide. About 16 percent of the uninsured were principally self-employed in 1985; among self-employed workers, one-quarter (24 percent) were uninsured.

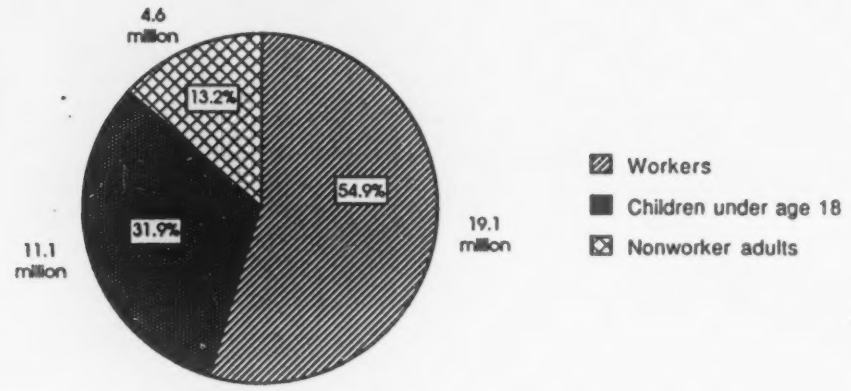
For most workers, noncoverage is not associated with unemployment. In 1985, 70 percent of uninsured full-time full-year workers reported no unemployment during the year. (This high rate of steady employment among uninsured workers corresponds to the 52 percent of all uninsured who lived in families of full-time, full-year workers who reported no unemployment during the year.) Among workers who reported any unemployment in 1985, the proportion that reported coverage at any time that year from an employer plan (a potential source of continued coverage) declined steadily with greater reported unemployment. The long-term unemployed were least likely to report employer-based coverage at any time during the year. In 1985, 52 percent of workers unemployed 13 weeks or more reported coverage at some time during the year from an employer plan, compared to 68 percent of workers who reported 1 to 4 weeks of unemployment.

Nonelderly Population by Selected Sources of Health Insurance Coverage and Own Work Status, 1985

Own work status	Total	Insured Population: Employer-provided	Insured Population: Other private	Insured Population: Public	No Health Insurance Coverage
		(in millions)			
Total	199.8	131.8	23.0	23.9	34.8
Family Head Workers	78.8	53.6	10.0	8.7	12.3
Other Family Workers	44.5	34.0	4.8	2.1	6.8
Nonworkers	76.5	44.3	8.2	13.1	15.6
Children	56.4	34.9	4.1	9.1	11.1
Others	20.2	9.4	4.1	4.0	4.6
		(percent within source of coverage groups)			
Total	100.0%	100.0%	100.0%	100.0%	100.0%
Family Head Workers	39.4%	40.7%	43.5%	36.4%	35.3%
Other Family Workers	22.3%	25.8%	20.9%	8.8%	19.5%
Nonworkers	38.3%	33.6%	35.7%	54.8%	44.8%
Children	28.2%	26.5%	17.8%	38.1%	31.9%
Others	10.1%	7.1%	17.8%	16.7%	13.2%
		(percent within worker categories)			
Total	100.0%	66.0%	11.5%	12.0%	17.4%
Family Head Workers	100.0%	68.0%	12.7%	11.0%	15.6%
Other Family Workers	100.0%	76.4%	10.8%	4.7%	15.3%
Nonworkers	100.0%	57.9%	10.7%	17.1%	20.4%
Children	100.0%	61.9%	7.3%	16.1%	19.7%
Others	100.0%	46.5%	20.3%	19.8%	22.8%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Nonelderly Population Without Health Insurance Coverage by Own Work Status, 1985



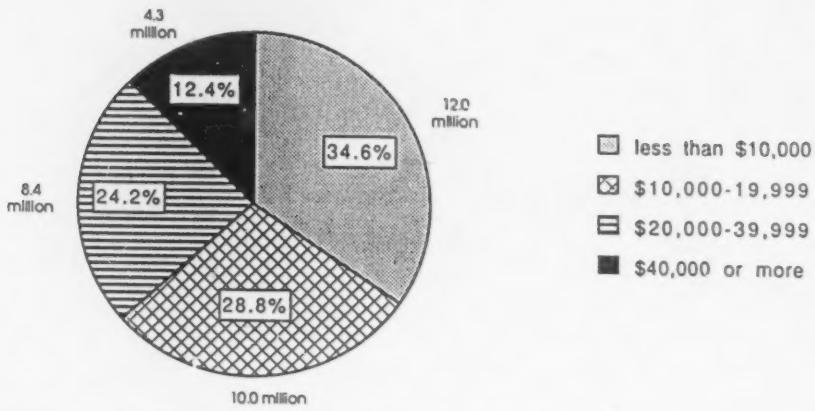
Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Nonelderly Population by Selected Sources of Health Insurance Coverage and Family Income, 1985

		Insured Population: Private & Public				No Health
			Employer-provided			Insurance
Family Income	Total	Total	Total	Direct	Indirect	Coverage
		(in millions)				
Total	199.8	165.0	131.8	68.3	63.5	34.8
less than $10,000	31.7	19.7	4.5	2.9	1.6	12.0
$10,000-19,999	37.6	27.5	20.2	11.7	8.5	10.0
$20,000-29,999	38.1	32.9	28.7	14.5	14.2	5.2
$30,000-39,999	33.0	29.9	27.3	13.0	14.3	3.2
$40,000 or more	59.3	55.1	51.1	26.2	25.0	4.3
		(percents within source of coverage groups)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
less than $10,000	15.9%	11.9%	3.4%	4.2%	2.5%	34.5%
$10,000-19,999	18.8%	16.7%	15.3%	17.1%	13.4%	28.8%
$20,000-29,999	19.1%	19.9%	21.8%	21.2%	22.4%	15.0%
$30,000-39,999	16.5%	18.1%	20.7%	19.0%	22.5%	9.2%
$40,000 or more	29.7%	33.4%	38.8%	38.4%	39.4%	12.4%
		(percents within income groups)				
Total	100.0%	82.6%	66.0%	34.2%	31.8%	17.4%
less than $10,000	100.0%	62.1%	14.2%	9.1%	5.0%	37.9%
$10,000-19,999	100.0%	73.1%	53.7%	31.1%	22.6%	26.6%
$20,000-29,999	100.0%	86.4%	75.3%	38.1%	37.3%	13.6%
$30,000-39,999	100.0%	90.6%	82.7%	39.4%	43.3%	9.7%
$40,000 or more	100.0%	92.9%	86.2%	44.2%	42.2%	7.3%

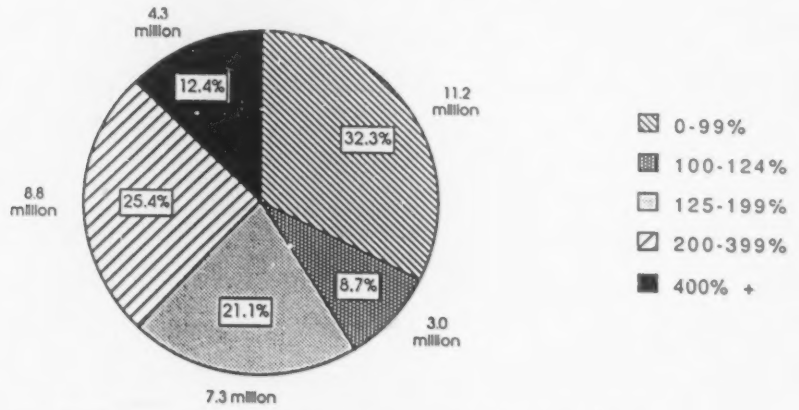
Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Nonelderly Population Without Health Insurance Coverage
by Family Income, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Nonelderly Population Without Health Insurance Coverage by Family
Income as a Percent of Poverty, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Nonelderly Population by Selected Sources of Health Insurance Coverage, Own Work Status and Poverty Status, 1985

Work/ Poverty Status	Total	Insured Population: Private & Public					No Health Insurance Coverage
		Private Coverage			Public Coverage		
		Total	Employer	Other	Total	Medicaid	
Total Population (in millions)							
Total	199.8	147.6	131.8	23.0	23.9	16.0	34.8
Workers	123.3	97.1	87.6	14.8	10.8	6.1	19.1
Family Head	78.8	60.3	53.6	10.0	8.7	5.4	12.3
Others	44.5	36.8	34.0	4.8	2.1	0.7	6.8
Nonworkers	76.5	50.6	44.3	8.2	13.1	10.0	15.6
Children	56.4	37.7	34.9	4.1	9.1	7.9	11.1
Others	20.2	12.8	9.4	4.1	4.0	2.1	4.6
Poor Population (in millions)							
Total	29.5	6.2	3.9	2.5	13.1	12.2	11.2
Workers	13.5	3.3	2.0	1.5	5.1	4.4	5.6
Family Head	12.1	2.8	1.6	1.3	4.8	4.2	4.9
Others	1.4	0.5	0.4	0.2	0.3	0.2	0.7
Nonworkers	16.0	2.8	1.9	1.0	8.0	7.7	5.7
Children	12.9	2.2	1.6	0.7	6.8	6.6	4.3
Others	3.2	0.6	0.3	0.3	1.2	1.1	1.4
Near-Poor Population (in millions)							
Total	8.1	3.9	3.1	1.0	1.6	1.1	3.0
Workers	4.0	2.0	1.5	0.5	0.8	0.4	1.5
Family Head	3.1	1.5	1.1	0.4	0.7	0.4	1.1
Others	0.9	0.5	0.4	0.1	0.1	a	0.4
Nonworkers	4.2	1.9	1.5	0.5	0.8	0.6	1.6
Children	3.0	1.5	1.3	0.3	0.5	0.4	1.1
Others	1.2	0.4	0.3	0.2	0.3	0.4	0.5
Total Population (percent within work status groups)							
Total	100.0%	73.9%	66.0%	11.5%	12.0%	8.0%	17.4%
Workers	100.0%	78.8%	71.0%	12.0%	8.8%	4.9%	15.5%
Family Head	100.0%	76.5%	68.0%	12.7%	11.1%	6.9%	15.7%
Others	100.0%	82.7%	76.4%	10.8%	4.7%	1.6%	15.2%
Nonworkers	100.0%	66.1%	57.9%	10.7%	17.1%	13.1%	20.4%
Children	100.0%	66.8%	61.9%	7.3%	16.1%	14.0%	19.6%
Others	100.0%	63.4%	46.5%	20.3%	20.0%	10.4%	22.7%
Poor Population (percent within work status groups)							
Total	100.0%	21.0%	13.4%	8.3%	44.2%	41.4%	38.0%
Workers	100.0%	24.4%	14.8%	11.1%	37.8%	32.6%	41.5%
Family Head	100.0%	23.1%	13.5%	10.7%	39.5%	34.7%	40.4%
Others	100.0%	35.7%	26.9%	13.1%	20.2%	14.3%	45.6%
Nonworkers	100.0%	17.5%	12.1%	6.1%	49.9%	48.1%	35.6%
Children	100.0%	17.1%	12.4%	5.3%	52.6%	51.2%	33.5%
Others	100.0%	18.8%	11.0%	9.6%	39.1%	34.4%	43.9%
Near-Poor Population (percent within work status groups)							
Total	100.0%	48.1%	37.6%	12.3%	19.1%	13.6%	37.4%
Workers	100.0%	50.0%	37.5%	12.5%	20.0%	10.0%	37.5%
Family Head	100.0%	48.4%	36.3%	14.5%	21.3%	12.9%	35.4%
Others	100.0%	55.6%	43.6%	11.3%	10.6%	a	40.3%
Nonworkers	100.0%	45.2%	37.3%	10.9%	19.2%	14.3%	38.2%
Children	100.0%	50.0%	42.9%	9.3%	16.1%	13.3%	37.2%
Others	100.0%	33.3%	23.1%	14.9%	27.1%	33.3%	40.8%

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Nonelderly Population by Selected Sources of Health Insurance Coverage, Own Work Status and Poverty Status, 1985, con't.

Work/ Poverty Status	Total	Insured Population: Private & Public					No Health Insurance Coverage
		Private Coverage			Public Coverage		
		Total	Employer	Other	Total	Medicaid	
		Total Population (percent within coverage groups)					
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Workers	61.7%	65.8%	66.5%	64.3%	45.2%	38.1%	54.9%
Family Head	39.4%	40.9%	40.7%	43.5%	36.4%	33.8%	35.3%
Others	22.3%	24.9%	25.8%	20.9%	8.8%	4.4%	19.5%
Nonworkers	38.3%	34.3%	33.6%	35.7%	54.8%	62.5%	44.8%
Children	28.2%	25.5%	26.5%	17.8%	38.1%	49.4%	31.9%
Others	10.1%	8.7%	7.1%	17.8%	16.7%	13.1%	13.2%
		Poor Population (percent within coverage groups)					
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Workers	45.8%	53.2%	51.3%	60.0%	38.9%	36.1%	50.0%
Family Head	41.0%	45.2%	41.0%	52.0%	36.6%	34.4%	43.8%
Others	4.7%	8.1%	10.3%	8.0%	2.3%	1.6%	6.3%
Nonworkers	54.2%	45.2%	48.7%	40.0%	61.1%	63.1%	50.9%
Children	43.7%	35.5%	41.0%	28.0%	51.9%	54.1%	38.4%
Others	10.8%	9.7%	7.7%	12.0%	9.2%	9.0%	12.5%
		Near-Poor Population (percent within coverage groups)					
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Workers	49.4%	51.3%	48.4%	50.0%	50.0%	36.4%	50.0%
Family Head	38.3%	38.5%	35.5%	40.0%	43.8%	36.4%	36.7%
Others	11.1%	12.8%	12.9%	10.0%	6.3%	a	13.3%
Nonworkers	51.9%	48.7%	48.4%	50.0%	50.0%	54.5%	53.3%
Children	37.0%	38.5%	41.9%	30.0%	31.3%	36.4%	36.7%
Others	14.8%	10.3%	9.7%	20.0%	18.8%	36.4%	16.7%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.
a--Number too small to be statistically reliable.

Nonelderly Population by Selected Sources of Health Insurance Coverage, Family Type, Family Head's Employment Status and Poverty Status, 1985

Family Type and Unemployment/ Poverty Status	Total	Insured Population: Private & Public					No Health Insurance Coverage
		Private Coverage			Public Coverage		
		Total	Employer	Other	Total	Medicaid	
		Total Population (in millions)					
Total	199.8	147.6	131.8	23.0	23.9	16.0	34.8
Spouse Present,							
No Child Present	40.2	33.4	28.6	7.1	3.6	0.6	5.1
Full-year worker	35.1	30.4	27.9	4.5	2.1	0.2	4.0
Part-Year Worker	1.6	1.2	0.8	0.6	0.3	a	0.3
Nonworker	3.5	2.0	a	2.0	1.2	0.3	0.8
Spouse Present,							
Child Present	95.6	79.6	75.0	7.8	6.6	4.1	12.1
Full-year worker	91.0	78.0	74.1	7.0	4.7	2.5	10.8
Part-Year Worker	2.3	1.3	0.9	0.5	0.4	0.3	0.7
Nonworker	2.3	0.4	a	0.4	1.4	1.3	0.6
No Spouse Present,							
No Child Present	34.3	22.8	18.6	5.5	3.6	2.0	8.7
Full-year worker	27.7	20.5	17.9	3.8	1.5	0.6	6.2
Part-Year Worker	2.4	1.2	0.7	0.6	0.3	0.2	0.9
Nonworker	4.2	1.0	a	1.0	1.9	1.2	1.6
No Spouse Present,							
Child Present	29.6	11.6	9.6	2.5	10.1	9.4	8.8
Full-year worker	18.0	10.1	8.8	1.7	2.6	2.2	5.9
Part-Year Worker	4.0	1.2	0.7	0.5	1.8	1.7	1.2
Nonworker	7.6	0.4	a	0.4	5.7	5.5	1.7
		Poor and Near-Poor Population (in millions)					
Total	37.6	10.1	7.0	3.5	14.7	13.3	14.2
Spouse Present,							
No Child	2.3	0.8	0.3	0.5	0.6	0.3	1.0
Full-year worker	1.0	0.4	0.3	0.1	0.1	0.1	0.5
Part-Year Worker	0.3	0.1	0.1	0.1	0.1	a	0.1
Nonworker	1.0	0.3	a	0.3	0.4	0.2	0.4
Spouse Present,							
Child Present	12.6	5.0	4.2	1.1	3.2	2.9	4.8
Full-year worker	9.8	4.6	4.0	0.7	1.7	1.5	3.9
Part-Year Worker	1.0	0.3	0.3	0.1	0.3	0.3	0.4
Nonworker	1.8	0.1	a	0.1	1.3	1.2	0.5
No Spouse Present,							
No Child	7.0	1.7	0.8	1.0	1.8	1.4	3.6
Full-year worker	2.8	1.0	0.6	0.3	0.3	0.3	1.7
Part-Year Worker	1.2	0.4	0.2	0.3	0.1	0.1	0.7
Nonworker	3.0	0.4	a	0.4	1.4	1.0	1.3
No Spouse Present,							
Child Present	15.8	2.4	1.6	0.9	8.9	8.7	4.9
Full-year worker	5.6	1.6	1.2	0.4	1.7	1.6	2.5
Part-Year Worker	3.0	0.5	0.4	0.2	1.8	1.7	0.9
Nonworker	7.2	0.2	a	0.2	5.6	5.4	1.6

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

Percent of Nonelderly Population Within Health Insurance Coverage Groups by Family Type, Family Head's Employment Status and Poverty Status, 1985

Unemployment/ Poverty Status	Total	Insured Population: Private & Public					No Health Insurance Coverage
		Private Coverage			Public Coverage		
		Total	Employer	Other	Total	Medicaid	
Total Population							
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Spouse Present,							
No Child Present	20.1%	22.6%	21.7%	30.9%	15.1%	3.8%	14.7%
Full-year worker	17.6%	20.6%	21.2%	19.6%	8.8%	1.3%	11.5%
Part-Year Worker	0.8%	0.3%	0.6%	2.6%	1.3%	a	0.9%
Nonworker	1.8%	1.4%	a	8.7%	5.0%	1.9%	2.3%
Spouse Present,							
Child Present	47.8%	53.9%	56.9%	33.9%	27.6%	25.6%	34.8%
Full-year worker	45.5%	52.8%	56.2%	30.4%	19.7%	15.6%	31.0%
Part-Year Worker	1.2%	0.9%	0.7%	2.2%	1.7%	1.9%	2.0%
Nonworker	1.2%	0.3%	a	1.7%	5.9%	8.1%	1.7%
No Spouse Present,							
No Child Present	17.2%	15.4%	14.1%	23.9%	15.1%	12.5%	25.0%
Full-year worker	13.9%	13.9%	13.6%	16.5%	6.3%	3.8%	17.8%
Part-Year Worker	1.2%	0.8%	0.5%	2.6%	1.3%	1.3%	2.6%
Nonworker	2.1%	0.7%	a	4.3%	7.9%	7.5%	4.6%
No Spouse Present,							
Child Present	14.8%	7.9%	7.3%	10.9%	42.3%	58.8%	25.3%
Full-year worker	9.0%	6.8%	6.7%	7.4%	10.9%	13.8%	17.0%
Part-Year Worker	2.0%	0.8%	0.5%	2.2%	7.5%	10.6%	3.4%
Nonworker	3.8%	0.3%	a	1.7%	23.8%	34.4%	4.9%
Poor and Near Poor Population							
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Spouse Present,							
No Child	6.1%	7.9%	4.3%	14.3%	4.1%	2.3%	7.0%
Full-year worker	2.7%	4.0%	4.3%	2.9%	0.7%	0.8%	3.5%
Part-Year Worker	0.8%	1.0%	1.4%	2.9%	0.7%	a	0.7%
Nonworker	2.7%	3.0%	a	8.6%	2.7%	1.5%	2.8%
Spouse Present,							
Child Present	33.5%	49.5%	60.0%	31.4%	21.8%	21.8%	33.8%
Full-year worker	26.1%	45.5%	57.1%	20.0%	11.6%	11.3%	27.5%
Part-Year Worker	2.7%	3.0%	4.3%	2.9%	2.0%	2.3%	2.8%
Nonworker	4.8%	1.0%	a	2.9%	8.8%	9.0%	3.5%
No Spouse Present,							
No Child	18.6%	16.8%	11.4%	28.6%	12.2%	10.5%	25.4%
Full-year worker	7.4%	9.9%	8.6%	8.6%	2.0%	2.3%	12.0%
Part-Year Worker	3.2%	4.0%	2.9%	8.6%	0.7%	0.8%	4.9%
Nonworker	8.0%	4.0%	a	11.4%	9.5%	7.5%	9.2%
No Spouse Present,							
Child Present	42.0%	23.8%	22.9%	25.7%	60.5%	65.4%	34.5%
Full-year worker	14.9%	15.8%	17.1%	11.4%	11.6%	12.0%	17.6%
Part-Year Worker	8.0%	5.0%	5.7%	5.7%	12.2%	12.8%	6.3%
Nonworker	19.1%	2.0%	a	5.7%	38.1%	40.6%	11.3%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

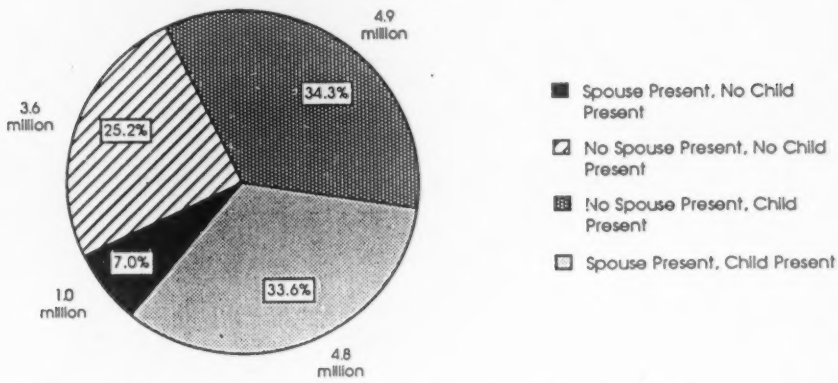
Percent of Nonelderly Population with Selected Sources of Health Insurance Coverage by Family Type, Family Head's Employment Status and Poverty Status, 1985

Family Type and Unemployment/ Poverty Status	Total	Insured Population: Private & Public					No Health Insurance Coverage
		Private Coverage			Public Coverage		
		Total	Employer	Other	Total	Medicaid	
Total Population							
Total	100.0%	73.9%	66.0%	11.5%	12.0%	8.0%	17.4%
Spouse Present,							
No Child Present	100.0%	83.1%	71.1%	17.7%	9.0%	1.5%	12.7%
Full-year worker	100.0%	86.6%	79.5%	12.8%	6.0%	0.6%	11.4%
Part-Year Worker	100.0%	75.0%	50.0%	37.5%	18.8%	a	18.8%
Nonworker	100.0%	57.1%	a	57.1%	34.3%	8.6%	22.9%
Spouse Present,							
Child Present	100.0%	83.3%	78.5%	8.2%	6.9%	4.3%	12.7%
Full-year worker	100.0%	85.7%	81.4%	7.7%	5.2%	2.7%	11.9%
Part-Year Worker	100.0%	56.5%	39.1%	21.7%	17.4%	13.0%	30.4%
Nonworker	100.0%	17.4%	a	17.4%	60.9%	56.5%	26.1%
No Spouse Present,							
No Child Present	100.0%	66.5%	54.2%	16.0%	10.5%	5.8%	25.4%
Full-year worker	100.0%	74.0%	64.6%	13.7%	5.4%	2.2%	22.4%
Part-Year Worker	100.0%	50.0%	29.2%	25.0%	12.5%	8.3%	37.5%
Nonworker	100.0%	23.8%	a	23.8%	45.2%	28.6%	38.1%
No Spouse Present,							
Child Present	100.0%	39.2%	32.4%	8.4%	34.1%	31.8%	29.7%
Full-year worker	100.0%	56.1%	48.9%	9.4%	14.4%	12.2%	32.8%
Part-Year Worker	100.0%	30.0%	17.5%	12.5%	45.0%	42.5%	30.0%
Nonworker	100.0%	5.3%	a	5.3%	75.0%	72.4%	22.4%
Poor and Near Poor Population							
Total	100.0%	26.9%	18.6%	9.3%	39.1%	35.4%	37.8%
Spouse Present,							
No Child	100.0%	34.8%	13.0%	21.7%	26.1%	13.0%	43.5%
Full-year worker	100.0%	40.0%	30.0%	10.0%	10.0%	10.0%	50.0%
Part-Year Worker	100.0%	33.3%	33.3%	33.3%	33.3%	a	33.3%
Nonworker	100.0%	30.0%	a	30.0%	40.0%	20.0%	40.0%
Spouse Present,							
Child Present	100.0%	39.7%	33.3%	8.7%	25.4%	23.0%	38.1%
Full-year worker	100.0%	46.9%	40.8%	7.1%	17.3%	15.3%	39.8%
Part-Year Worker	100.0%	30.0%	30.0%	10.0%	30.0%	30.0%	40.0%
Nonworker	100.0%	5.6%	a	5.6%	72.2%	66.7%	27.8%
No Spouse Present,							
No Child	100.0%	24.3%	11.4%	14.3%	25.7%	20.0%	51.4%
Full-year worker	100.0%	35.7%	21.4%	10.7%	10.7%	10.7%	60.7%
Part-Year Worker	100.0%	33.3%	16.7%	25.0%	8.3%	8.3%	58.3%
Nonworker	100.0%	13.3%	a	13.3%	46.7%	33.3%	43.3%
No Spouse Present,							
Child Present	100.0%	15.2%	10.1%	5.7%	56.3%	55.1%	31.0%
Full-year worker	100.0%	28.6%	21.4%	7.1%	30.4%	28.6%	44.6%
Part-Year Worker	100.0%	16.7%	13.3%	6.7%	60.0%	56.7%	30.0%
Nonworker	100.0%	2.8%	a	2.8%	77.8%	75.0%	22.2%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

Poor and Near Poor Nonelderly Population Without Health Insurance Coverage by Family Status, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

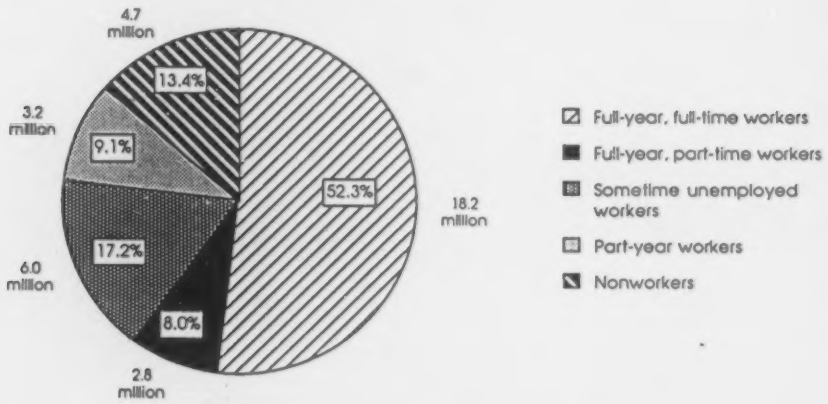
Nonelderly Population by Selected Sources of Health Insurance Coverage and Employment Status of Family Head, 1985

Work Status of Family Head	Total	Insured Population: Private & Public				No Health Insurance Coverage
		Total	Employer-provided			
			Total	Direct	Indirect	
	(in millions)					
Total	199.8	165.0	131.8	68.3	63.5	34.8
Full-year, full-time workers	143.5	125.3	115.7	59.4	56.3	18.2
Full-year, part-time workers	8.7	5.9	3.1	1.7	1.3	2.8
Sometime unemployed workers	19.6	13.6	9.9	5.3	4.6	6.0
Part-year workers	10.3	7.1	3.1	1.8	1.3	3.2
Nonworkers	17.7	13.1	a	a	a	4.7
	(percent within source of coverage groups)					
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Full-year, full-time workers	71.8%	75.9%	87.8%	87.0%	88.7%	52.3%
Full-year, part-time workers	4.4%	3.6%	2.4%	2.5%	2.0%	8.0%
Sometime unemployed workers	9.8%	8.2%	7.5%	7.8%	7.2%	17.2%
Part-year workers	5.2%	4.3%	2.4%	2.6%	2.0%	9.2%
Nonworkers	8.9%	7.9%	a	a	a	13.5%
	(percent within worker categories)					
Total	100.0%	82.6%	66.0%	34.2%	31.8%	17.4%
Full-year, full-time workers	100.0%	87.3%	80.6%	41.4%	39.2%	12.7%
Full-year, part-time workers	100.0%	67.3%	35.6%	19.5%	14.9%	32.2%
Sometime unemployed workers	100.0%	69.4%	50.5%	27.0%	23.5%	30.6%
Part-year workers	100.0%	68.9%	30.1%	17.5%	12.6%	31.1%
Nonworkers	100.0%	74.0%	a	a	a	26.6%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

Nonelderly Population Without Health Insurance by Employment Status of Family Head, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Nonelderly Population by Selected Sources of Health Insurance Coverage by Industry and Family Head's Number of Employers During the Year, 1985 (in millions)

	Total	Employer-based			No Health Insurance Coverage
		Total	Direct	Indirect	
Total	199.8	131.8	68.3	63.5	34.8
1 employer	157.4	116.9	60.0	56.9	23.8
2 employers	18.5	11.5	6.2	4.9	4.1
3 employers	5.9	2.9	1.5	1.2	1.7
Self-employed	11.9	5.9	2.6	3.3	3.0
1 employer	10.9	5.4	2.4	3.0	2.7
2 employers	0.8	0.4	0.2	0.2	0.2
3 employers	0.2	a	a	a	0.1
Mining	2.7	2.4	1.0	1.4	0.3
1 employer	2.3	2.1	0.8	1.2	0.2
2 employers	0.3	0.3	0.1	0.1	a
3 employers	0.1	a	a	a	a
Construction	13.0	8.5	4.1	4.4	3.1
1 employer	9.7	6.7	3.2	3.5	2.1
2 employers	1.9	1.1	0.5	0.5	0.6
3 employers	1.3	0.7	0.3	0.4	0.4
Manufacturing	44.9	37.9	18.9	18.9	4.9
1 employer	40.6	34.8	17.2	17.5	4.1
2 employers	3.4	2.4	1.3	1.1	0.6
3 employers	0.9	0.6	0.4	0.3	0.2
Transportation, Communication & Other Public Utilities	16.5	13.9	6.7	7.2	1.7
1 employer	14.9	12.8	6.2	6.6	1.4
2 employers	1.2	0.9	0.4	0.4	0.2
3 employers	0.3	0.2	0.1	0.1	0.1
Wholesale trade	8.2	6.6	3.3	3.3	1.1
1 employer	7.1	5.8	2.9	2.9	0.8
2 employers	1.0	0.7	0.4	0.3	0.1
3 employers	0.2	0.1	a	a	a
Retail trade	21.5	11.5	6.4	5.0	5.8
1 employer	17.3	9.6	5.4	4.2	4.3
2 employers	3.2	1.5	0.8	0.6	1.0
3 employers	1.0	0.4	0.2	0.1	0.4
Finance, Insurance & Real Estate	9.6	7.4	4.3	3.2	1.2
1 employer	8.3	6.5	3.6	2.9	1.0
2 employers	1.0	0.7	0.5	0.3	0.2
3 employers	0.3	0.2	0.1	a	a
Business & Repair Services	7.5	4.7	2.6	2.1	1.9
1 employer	6.0	3.9	2.1	1.8	1.3
2 employers	1.1	0.5	0.3	0.2	0.4
3 employers	0.4	0.2	0.1	0.1	0.2
Personal Services	4.3	1.6	0.9	0.7	1.5
1 employer	3.5	1.3	0.8	0.6	1.2
2 employers	0.6	0.2	0.1	0.1	0.2
3 employers	0.2	a	a	a	0.1
Entertainment & Recreation Services	1.5	0.7	0.4	0.3	0.4
1 employer	1.1	0.5	0.3	0.2	0.3
2 employers	0.2	0.1	a	a	a
3 employers	0.1	a	a	a	a
Professional and Related Services	29.8	22.0	12.4	9.5	4.3
1 employer	25.9	19.3	10.9	8.4	3.6
2 employers	3.1	2.2	1.3	0.9	0.5
3 employers	0.8	0.5	0.3	0.2	0.2
Public Administration	10.6	8.8	4.5	4.3	0.9
1 employer	9.8	8.2	4.2	4.1	0.8
2 employers	0.7	0.5	0.3	0.2	0.1
3 employers	0.1	a	a	a	a
No Industry	17.7	a	a	a	4.7

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

Percent of Nonelderly Population with Selected Sources of Health Insurance Coverage by Industry and Family Head's Number of Employers During the Year, 1985

	Total	Employer-based			No Health Insurance Coverage
		Total	Direct	Indirect	
Total	100.0%	66.0%	34.2%	31.8%	17.4%
1 employer	100.0%	74.3%	38.1%	36.1%	15.1%
2 employers	100.0%	62.2%	33.5%	26.5%	22.2%
3 employers	100.0%	49.2%	25.4%	20.3%	28.8%
Self-employed	100.0%	49.6%	21.8%	27.7%	25.2%
1 employer	100.0%	49.5%	22.0%	27.5%	24.8%
2 employers	100.0%	50.0%	25.0%	25.0%	25.0%
3 employers	100.0%	a	a	a	50.0%
Mining	100.0%	88.9%	37.0%	51.9%	11.1%
1 employer	100.0%	91.3%	34.8%	52.2%	8.7%
2 employers	100.0%	100.0%	33.3%	33.3%	a
3 employers	100.0%	a	a	a	a
Construction	100.0%	65.4%	31.5%	33.8%	23.8%
1 employer	100.0%	69.1%	33.0%	36.1%	21.6%
2 employers	100.0%	57.9%	26.3%	26.3%	31.6%
3 employers	100.0%	53.8%	23.1%	30.8%	30.8%
Manufacturing	100.0%	84.4%	42.1%	42.1%	10.9%
1 employer	100.0%	85.7%	42.4%	43.1%	10.1%
2 employers	100.0%	70.5%	38.2%	32.4%	17.6%
3 employers	100.0%	66.7%	44.4%	33.3%	22.2%
Transportation, Communication & Other Public Utilities	100.0%	84.2%	40.6%	43.6%	10.3%
1 employer	100.0%	85.9%	41.6%	44.3%	9.4%
2 employers	100.0%	75.0%	33.3%	33.3%	16.7%
3 employers	100.0%	66.7%	33.3%	33.3%	33.3%
Wholesale trade	100.0%	80.5%	40.2%	40.2%	13.4%
1 employer	100.0%	81.7%	40.8%	40.8%	11.3%
2 employers	100.0%	70.0%	40.0%	30.0%	10.0%
3 employers	100.0%	50.0%	a	a	a
Retail trade	100.0%	53.5%	29.8%	23.3%	27.0%
1 employer	100.0%	55.5%	31.2%	24.3%	24.9%
2 employers	100.0%	46.9%	25.0%	18.8%	31.3%
3 employers	100.0%	40.0%	20.0%	10.0%	40.0%
Finance, Insurance & Real Estate	100.0%	77.1%	44.8%	33.3%	12.5%
1 employer	100.0%	78.3%	43.4%	34.9%	12.0%
2 employers	100.0%	70.0%	50.0%	30.0%	20.0%
3 employers	100.0%	66.7%	33.3%	a	a
Business & Repair Services	100.0%	62.7%	34.7%	28.0%	25.3%
1 employer	100.0%	65.0%	35.0%	30.0%	21.7%
2 employers	100.0%	45.5%	27.3%	18.2%	36.4%
3 employers	100.0%	50.0%	25.0%	25.0%	50.0%
Personal Services	100.0%	37.2%	20.9%	16.3%	34.9%
1 employer	100.0%	37.1%	22.9%	17.1%	34.3%
2 employers	100.0%	33.3%	16.7%	16.7%	33.3%
3 employers	100.0%	a	a	a	50.0%
Entertainment & Recreation Services	100.0%	46.7%	26.7%	20.0%	26.7%
1 employer	100.0%	45.5%	27.3%	18.2%	27.3%
2 employers	100.0%	50.0%	a	a	a
3 employers	100.0%	a	a	a	a
Professional and Related Services	100.0%	73.8%	41.6%	31.9%	14.4%
1 employer	100.0%	74.5%	42.1%	32.4%	13.9%
2 employers	100.0%	71.0%	41.9%	29.0%	16.1%
3 employers	100.0%	62.5%	37.5%	25.0%	25.0%
Public Administration	100.0%	83.0%	42.5%	40.6%	8.5%
1 employer	100.0%	83.7%	42.9%	41.8%	8.2%
2 employers	100.0%	71.4%	42.9%	28.6%	14.3%
3 employers	100.0%	a	a	a	a
No Industry	100.0%	a	a	a	26.6%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

Nonelderly Population by Selected Sources of Health Insurance Coverage by Family Head's Industry and Number of Hours Worked Per Week, 1985

	Total	Employer-based			No Health Insurance Coverage
		Total	Direct	Indirect	
Total	199.8	131.8	68.3	63.5	34.8
Less than 17 hours	4.0	0.6	0.3	0.3	1.4
18 hours or more	178.0	131.2	67.9	63.2	28.7
Self-employed	11.9	5.9	2.6	3.3	3.0
Less than 17 hours	0.2	a	a	a	0.1
18 hours or more	11.7	5.8	2.6	3.2	2.9
Mining	2.7	2.4	1.0	1.4	0.3
Less than 17 hours	a	a	a	a	a
18 hours or more	2.7	2.4	1.0	1.4	0.3
Construction	13.0	8.5	4.1	4.4	3.1
Less than 17 hours	0.1	a	a	a	a
18 hours or more	12.9	8.4	4.1	4.4	3.1
Manufacturing	44.9	37.9	18.9	18.9	4.9
Less than 17 hours	0.2	a	a	a	0.1
18 hours or more	44.7	37.8	18.9	18.9	4.8
Transportation, Communication & Other Public Utilities	16.5	13.9	6.7	7.2	1.7
Less than 17 hours	0.1	a	a	a	0.1
18 hours or more	16.3	13.9	6.7	7.2	1.7
Wholesale trade	8.2	6.6	3.3	3.3	1.1
Less than 17 hours	0.1	a	a	a	a
18 hours or more	8.2	6.6	3.3	3.3	1.1
Retail trade	21.5	11.5	6.4	5.0	5.8
Less than 17 hours	1.1	0.1	0.1	0.1	0.4
18 hours or more	20.5	11.3	6.4	5.0	5.4
Finance, Insurance & Real Estate	9.6	7.4	4.3	3.2	1.2
Less than 17 hours	0.1	a	a	a	a
18 hours or more	9.4	7.4	4.2	3.2	1.2
Business & Repair Services	7.5	4.7	2.6	2.1	1.9
Less than 17 hours	0.2	a	a	a	0.1
18 hours or more	7.3	4.6	2.6	2.1	1.8
Personal Services	4.3	1.6	0.9	0.7	1.5
Less than 17 hours	0.6	a	a	a	0.2
18 hours or more	3.7	1.5	0.9	0.7	1.4
Entertainment & Recreation Services	1.5	0.7	0.4	0.3	0.4
Less than 17 hours	0.1	a	a	a	a
18 hours or more	1.4	0.7	0.4	0.3	0.3
Professional and Related Services	29.8	22.0	12.4	9.5	4.3
Less than 17 hours	1.1	0.2	0.1	0.1	0.3
18 hours or more	28.7	21.8	12.3	9.4	4.0
Public Administration	10.6	8.8	4.5	4.3	0.9
Less than 17 hours	0.2	a	a	a	0.1
18 hours or more	10.4	8.8	4.5	4.3	0.9

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

Percent of Nonelderly Population within Family Head's Industry with Selected Sources of Health Insurance Coverage by Number of Hours Worked Per Week, 1985

		Employer-based			No Health Insurance
	Total	Total	Direct	Indirect	Coverage
Total	100.0%	66.0%	34.2%	31.8%	17.4%
Less than 17 hours	100.0%	15.6%	7.7%	7.9%	34.9%
18 hours or more	100.0%	73.7%	38.2%	35.5%	16.1%
Self-employed	100.0%	49.4%	22.1%	27.3%	25.3%
Less than 17 hours	100.0%	a	a	a	39.1%
18 hours or more	100.0%	50.0%	22.3%	27.7%	25.0%
Mining	100.0%	87.0%	36.2%	50.8%	9.3%
Less than 17 hours	100.0%	a	a	a	a
18 hours or more	100.0%	87.1%	36.2%	50.9%	9.2%
Construction	100.0%	65.2%	31.4%	33.8%	23.8%
Less than 17 hours	100.0%	a	a	a	a
18 hours or more	100.0%	65.7%	31.7%	34.1%	23.8%
Manufacturing	100.0%	84.2%	42.1%	42.1%	10.9%
Less than 17 hours	100.0%	a	a	a	41.3%
18 hours or more	100.0%	84.5%	42.2%	42.3%	10.8%
Transportation, Communication & Other Public Utilities	100.0%	84.5%	41.0%	43.5%	10.5%
Less than 17 hours	100.0%	a	a	a	37.3%
18 hours or more	100.0%	85.1%	41.3%	43.8%	10.3%
Wholesale trade	100.0%	80.7%	40.5%	40.3%	13.0%
Less than 17 hours	100.0%	a	a	a	a
18 hours or more	100.0%	81.1%	40.7%	40.4%	12.9%
Retail trade	100.0%	53.2%	29.9%	23.4%	26.9%
Less than 17 hours	100.0%	11.8%	6.2%	5.6%	38.2%
18 hours or more	100.0%	55.4%	31.1%	24.3%	26.3%
Finance, Insurance & Real Estate	100.0%	77.6%	44.5%	33.1%	12.8%
Less than 17 hours	100.0%	a	a	a	a
18 hours or more	100.0%	78.6%	45.0%	33.5%	12.6%
Business & Repair Services	100.0%	62.0%	34.3%	27.7%	24.6%
Less than 17 hours	100.0%	a	a	a	39.8%
18 hours or more	100.0%	63.1%	35.0%	28.1%	24.2%
Personal Services	100.0%	37.1%	21.3%	15.8%	35.9%
Less than 17 hours	100.0%	a	a	a	33.4%
18 hours or more	100.0%	41.4%	24.0%	17.4%	36.2%
Entertainment & Recreation Services	100.0%	49.2%	29.0%	20.3%	24.9%
Less than 17 hours	100.0%	a	a	a	a
18 hours or more	100.0%	51.1%	30.4%	20.7%	24.5%
Professional and Related Services	100.0%	73.8%	41.7%	32.0%	14.5%
Less than 17 hours	100.0%	19.1%	9.2%	9.9%	31.5%
18 hours or more	100.0%	75.8%	43.0%	32.9%	13.9%
Public Administration	100.0%	83.0%	42.4%	40.6%	8.9%
Less than 17 hours	100.0%	a	a	a	36.9%
18 hours or more	100.0%	83.9%	42.9%	41.1%	8.5%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

Nonelderly Population by Selected Sources of Health Insurance Coverage and Region and State, 1985

	Total	Total Private	Employer	Other Private	Total Public	Medicaid	No Health Insurance
			(in. thousands)				
Total	199,765	147,645	131,814	22,950	23,924	16,038	34,759
New England	10,733	8,680	7,947	1,039	1,064	717	1,302
Maine	929	730	661	95	133	86	109
New Hampshire	863	729	676	79	a	a	109
Vermont	454	357	323	a	a	a	a
Massachusetts	5,022	3,956	3,637	464	549	413	657
Rhode Island	790	634	577	a	a	a	101
Connecticut	2,675	2,274	2,073	275	219	132	258
Middle Atlantic	31,412	23,618	21,296	3,384	4,080	3,299	4,521
New York	15,226	10,704	9,777	1,403	2,420	2,079	2,471
New Jersey	6,517	5,245	4,714	831	608	430	806
Pennsylvania	9,669	7,668	6,806	1,151	1,052	789	1,245
East North Central	35,678	27,195	24,606	3,798	4,755	3,738	4,894
Ohio	9,191	7,061	6,410	999	1,042	765	1,332
Indiana	4,537	3,585	3,225	499	301	164	769
Illinois	10,137	7,491	6,846	992	1,457	1,175	1,469
Michigan	7,886	5,904	5,287	892	1,438	1,195	940
Wisconsin	3,928	3,155	2,838	417	517	439	383
West North Central	13,928	10,923	9,485	1,625	1,470	1,006	1,957
Minnesota	3,410	2,793	2,430	498	357	251	383
Iowa	2,135	1,663	1,453	264	264	228	272
Missouri	4,234	3,147	2,774	452	485	314	697
North Dakota	500	412	339	93	a	a	a
South Dakota	504	386	324	84	a	a	89
Nebraska	1,224	979	836	184	96	a	185
Kansas	1,920	1,545	1,329	249	179	103	273
South Atlantic	32,627	23,840	21,152	4,301	3,908	2,082	6,123
Delaware	519	388	359	a	a	a	93
Maryland	3,641	2,837	2,541	422	364	217	546
District of Columbia	517	324	279	a	94	a	117
Virginia	4,549	3,474	3,217	436	456	236	754
West Virginia	1,571	1,075	916	210	282	204	292
North Carolina	5,066	3,907	3,504	669	553	218	824
South Carolina	2,713	2,079	1,867	343	351	213	392
Georgia	4,968	3,551	3,238	631	707	421	904
Florida	9,083	6,206	5,232	1,484	1,050	469	2,200
East South Central	12,511	8,805	7,694	1,614	1,477	924	2,641
Kentucky	3,001	2,169	1,859	447	320	201	638
Tennessee	3,944	2,727	2,401	467	519	326	834
Alabama	3,432	2,488	2,205	397	326	225	686
Mississippi	2,134	1,422	1,229	303	312	172	483
West South Central	22,487	15,708	14,047	2,415	2,202	1,167	5,255
Arkansas	1,928	1,242	1,091	223	325	180	469
Louisiana	3,741	2,707	2,345	559	301	151	822
Oklahoma	2,762	1,884	1,630	313	285	121	698
Texas	14,056	9,875	8,981	1,320	1,290	715	3,266
Mountain	10,889	8,135	7,109	1,369	1,047	415	2,114
Montana	668	496	415	103	77	a	123
Idaho	800	594	514	116	a	a	169
Wyoming	419	325	289	a	a	a	a
Colorado	2,795	2,157	1,904	345	199	96	513
New Mexico	1,228	796	710	122	199	85	286
Arizona	2,658	1,960	1,648	370	256	a	570
Utah	1,481	1,196	1,099	141	110	a	206
Nevada	839	612	531	119	89	a	179
Pacific	29,499	20,739	18,476	3,205	3,922	2,690	5,951
Washington	3,565	2,675	2,324	545	484	286	589
Oregon	2,268	1,766	1,521	338	198	103	388
California	22,422	15,312	13,788	2,119	3,076	2,218	4,803
Alaska	439	337	274	91	a	a	77
Hawaii	805	649	569	113	111	a	95

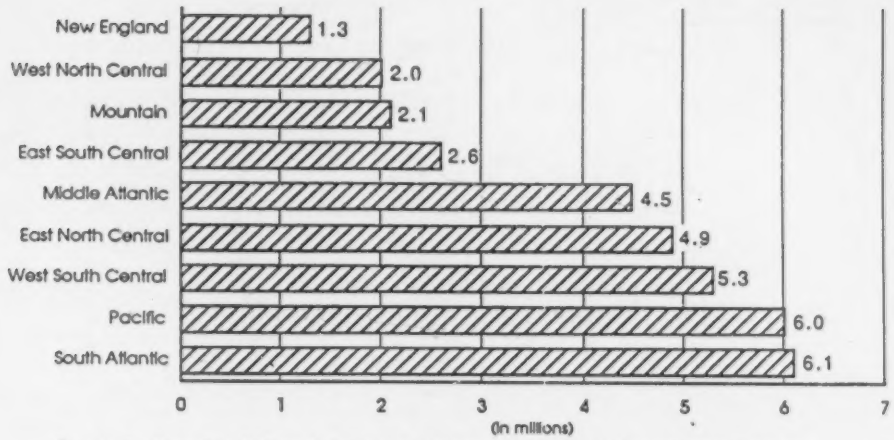
Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.
a--Number too small to be statistically reliable.

Nonelderly Population by Selected Sources of Health Insurance Coverage: Percent Distribution Within Region and State, 1985

	Total	Total Private	Employer	Other Private	Total Public	Medicaid	No Health Insurance
			(In thousands)				
Total	100.0%	73.9%	66.0%	11.5%	12.0%	8.0%	17.4%
New England	100.0%	80.9%	74.0%	9.7%	9.9%	6.7%	12.1%
Maine	100.0%	78.6%	71.1%	10.2%	14.3%	9.2%	11.7%
New Hampshire	100.0%	84.4%	78.3%	9.1%	a	a	12.6%
Vermont	100.0%	78.6%	71.1%	a	a	a	a
Massachusetts	100.0%	78.8%	72.4%	9.2%	10.9%	8.2%	13.1%
Rhode Island	100.0%	80.2%	73.0%	a	a	a	12.8%
Connecticut	100.0%	85.0%	77.5%	10.3%	8.2%	4.9%	9.7%
Middle Atlantic	100.0%	75.2%	67.8%	10.8%	13.0%	10.5%	14.4%
New York	100.0%	70.3%	64.2%	9.2%	15.9%	13.7%	16.2%
New Jersey	100.0%	80.5%	72.3%	12.7%	9.3%	6.6%	12.4%
Pennsylvania	100.0%	79.3%	70.4%	11.9%	10.9%	8.2%	12.9%
East North Central	100.0%	76.2%	69.0%	10.6%	13.3%	10.5%	13.7%
Ohio	100.0%	76.8%	69.7%	10.9%	11.3%	8.3%	14.5%
Indiana	100.0%	79.0%	71.1%	11.0%	6.6%	3.6%	16.9%
Illinois	100.0%	73.9%	67.5%	9.8%	14.4%	11.6%	14.5%
Michigan	100.0%	74.9%	67.0%	11.3%	18.2%	15.2%	11.9%
Wisconsin	100.0%	80.3%	72.2%	10.6%	13.2%	11.2%	9.8%
West North Central	100.0%	78.4%	68.1%	13.1%	10.6%	7.2%	14.1%
Minnesota	100.0%	81.9%	71.3%	14.6%	10.5%	7.4%	11.2%
Iowa	100.0%	77.9%	68.1%	12.4%	12.4%	10.7%	12.7%
Missouri	100.0%	74.3%	65.5%	10.7%	11.4%	7.4%	16.5%
North Dakota	100.0%	82.4%	67.7%	18.7%	a	a	a
South Dakota	100.0%	76.5%	64.3%	16.6%	a	a	17.7%
Nebraska	100.0%	80.0%	68.3%	15.0%	7.8%	a	15.1%
Kansas	100.0%	80.4%	69.2%	13.0%	9.3%	5.4%	14.2%
South Atlantic	100.0%	73.1%	64.8%	13.2%	12.0%	6.4%	18.8%
Delaware	100.0%	74.9%	69.2%	a	a	a	17.9%
Maryland	100.0%	77.9%	69.8%	11.6%	10.0%	6.0%	15.0%
District of Columbia	100.0%	62.7%	53.9%	a	18.2%	a	22.7%
Virginia	100.0%	76.4%	70.7%	9.6%	10.0%	5.2%	16.6%
West Virginia	100.0%	68.4%	58.3%	13.3%	17.9%	13.0%	18.6%
North Carolina	100.0%	77.1%	69.2%	13.2%	10.9%	4.3%	16.3%
South Carolina	100.0%	76.6%	68.8%	12.7%	12.9%	7.9%	14.4%
Georgia	100.0%	71.5%	65.2%	12.7%	14.2%	8.5%	18.2%
Florida	100.0%	68.3%	57.6%	16.3%	11.6%	5.2%	24.2%
East South Central	100.0%	70.4%	61.5%	12.9%	11.8%	7.4%	21.1%
Kentucky	100.0%	72.3%	62.0%	14.9%	10.7%	6.7%	21.2%
Tennessee	100.0%	69.1%	60.9%	11.9%	13.2%	8.3%	21.1%
Alabama	100.0%	72.5%	64.3%	11.6%	9.5%	6.5%	20.0%
Mississippi	100.0%	66.6%	57.6%	14.2%	14.6%	8.1%	22.6%
West South Central	100.0%	69.9%	62.5%	10.7%	9.8%	5.2%	23.4%
Arkansas	100.0%	64.4%	56.6%	11.6%	16.9%	9.3%	24.3%
Louisiana	100.0%	72.4%	62.7%	14.9%	8.1%	4.0%	22.0%
Oklahoma	100.0%	68.2%	59.0%	11.3%	10.3%	4.4%	25.3%
Texas	100.0%	70.3%	63.9%	9.4%	9.2%	5.1%	23.2%
Mountain	100.0%	74.7%	65.3%	12.6%	9.6%	3.8%	19.4%
Montana	100.0%	74.2%	62.1%	15.4%	11.5%	a	18.4%
Idaho	100.0%	74.2%	64.2%	14.5%	a	a	21.2%
Wyoming	100.0%	77.6%	69.0%	a	a	a	a
Colorado	100.0%	77.2%	68.1%	12.3%	7.1%	3.4%	18.4%
New Mexico	100.0%	64.8%	57.8%	9.9%	16.2%	6.9%	23.3%
Arizona	100.0%	73.7%	62.0%	13.9%	9.6%	a	21.4%
Utah	100.0%	80.8%	74.2%	9.5%	7.5%	a	13.9%
Nevada	100.0%	73.0%	63.3%	14.2%	10.6%	a	21.3%
Pacific	100.0%	70.3%	62.6%	10.9%	13.3%	9.1%	20.2%
Washington	100.0%	75.0%	65.2%	15.3%	13.6%	8.0%	16.5%
Oregon	100.0%	77.9%	67.1%	14.9%	8.7%	4.5%	17.1%
California	100.0%	68.3%	61.5%	9.5%	13.7%	9.9%	21.4%
Alaska	100.0%	76.6%	62.4%	20.7%	a	a	17.4%
Hawaii	100.0%	80.6%	70.7%	14.0%	13.8%	a	11.8%

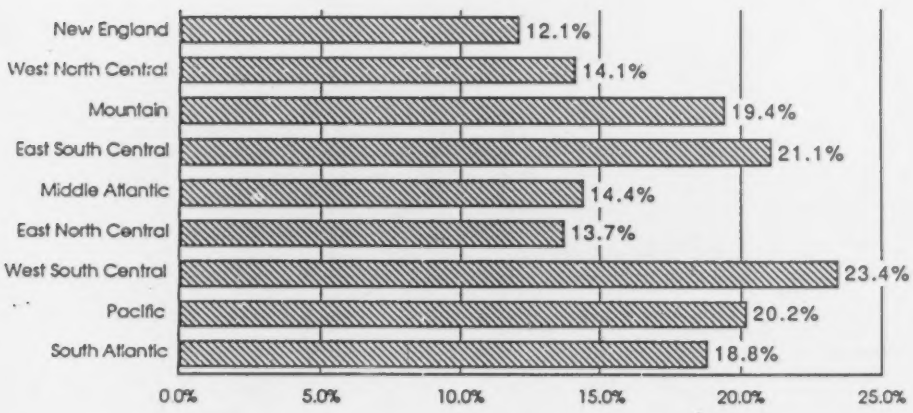
Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.
a--Number too small to be statistically reliable.

Nonelderly Population Without Health Insurance Coverage by Region, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Percent Within Region of the Nonelderly Population Without Health Insurance Coverage, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Nonelderly Population by Selected Sources of Health Insurance Coverage, Poverty Status, Region and State, 1985
(numbers in thousands)

		1%-124% of Poverty Level				125%-199% of Poverty Level			
	Total Population	Total	Employer-based Coverage	Medicaid Coverage	No Health Insurance Coverage	Total	Employer-based Coverage	Medicaid Coverage	No Health Insurance Coverage
New England	10,733	1,271	266	581	335	1195	702	a	280
Maine	929	162	a	a	a	180	113	a	a
New Hampshire	863	76	a	a	a	111	79	a	a
Vermont	454	a	a	a	a	a	a	a	a
Massachusetts	5,022	649	120	326	158	483	265	a	126
Rhode Island	790	93	a	a	a	95	a	a	a
Connecticut	2,675	229	a	112	a	258	153	a	a
Middle Atlantic	31,412	5,524	880	2,788	1,562	3,581	2,018	314	862
New York	15,226	3,235	480	1,778	882	1,828	1,027	195	476
New Jersey	6,517	711	105	341	201	627	338	a	165
Pennsylvania	9,669	1,578	295	669	479	1,126	654	85	221
East North Central	35,678	6,618	1,062	3,172		4,665	2,825	329	1,057
Ohio	9,191	1,601	211	676	563	1,191	756	a	252
Indiana	4,537	783	177	a	386	738	493	a	179
Illinois	10,137	2,127	367	1,070	596	1,213	747	a	282
Michigan	7,886	1,538	228	915	285	979	556	156	190
Wisconsin	3,928	569	84	363	92	545	273	a	153
West North Central	13,928	2,520	496	875	800	1,996	1,187	a	437
Minnesota	3,410	500	a	225	116	415	261	a	101
Iowa	2,135	511	118	201	139	237	141	a	a
Missouri	4,234	770	180	273	254	742	426	a	192
North Dakota	500	88	a	a	a	a	a	a	a
South Dakota	504	103	a	a	a	92	a	a	a
Nebraska	1,224	208	a	a	82	204	122	a	a
Kansas	1,920	341	a	84	140	238	140	a	a
South Atlantic	32,627	6,170	1,243	1,717	2,602	4,919	2,773	220	1,318
Delaware	519	91	a	a	a	a	a	a	a
Maryland	3,641	447	a	162	174	361	178	a	114
DC	517	135	a	a	a	90	a	a	a
Virginia	4,549	621	119	188	269	542	343	a	135
West Virginia	1,571	482	115	165	147	321	162	a	93
North Carolina	5,066	882	204	183	380	842	539	a	163
South Carolina	2,713	524	116	183	183	445	262	a	105
Georgia	4,968	1,086	212	372	383	747	407	a	224
Florida	9,083	1,903	369	377	987	1,499	119	a	433
East South Central	12,511	3,309	687	791	1,499	2,304	1,370	81	562
Kentucky	3,001	813	178	172	408	473	a	a	117
Tennessee	3,944	919	143	258	384	796	92	a	215
Alabama	3,432	889	236	a	376	603	a	a	158
Mississippi	2,134	688	130	164	331	432	a	a	a
West South Central	22,487	5,073	1,083	980	2,598	3,558	1,923	122	1,089
Arkansas	1,928	604	114	152	293	307	a	a	a
Louisiana	3,741	858	197	a	432	603	a	a	152
Oklahoma	2,762	564	80	98	321	444	a	a	171
Texas	14,056	3,047	693	612	1,552	2,204	185	a	707
Mountain	10,889	1,856	421	357	812	1,678	882	a	489
Montana	668	146	a	a	a	112	a	a	a
Idaho	800	167	a	a	a	156	94	a	a
Wyoming	419	a	a	a	a	a	a	a	a
Colorado	2,795	341	a	80	177	291	125	a	115
New Mexico	1,228	314	a	76,347	127	225	107	a	a
Arizona	2,658	398	83	a	206	430	201	a	119
Utah	1,481	258	101	a	a	276	183	a	a
Nevada	839	162	a	a	80	138	81	a	a
Pacific	29,499	5,340	871	1,983	2,147	3,929	1,923	438	1,237
Washington	3,565	571	93	230	198	510	298	a	141
Oregon	2,268	396	77	a	189	347	187	a	a
California	22,422	4,191	664	1,612	1,708	2,924	1,353	370	987
Alaska	439	a	a	a	a	a	a	a	a
Hawaii	805	121	a	a	a	103	a	a	a

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.
a--Number too small to be statistically reliable.

Percent within State and Region of the Nonelderly Population with Selected Sources of Health Insurance Coverage by Poverty Status, 1985

		1%-124% of Poverty Level				125%-199% of Poverty Level			
	Total Population	Total	Employer-based Coverage	Medicaid Coverage	No Health Insurance Coverage	Total	Employer-based Coverage	Medicaid Coverage	No Health Insurance Coverage
New England	100.0%	11.8%	2.5%	5.4%	3.1%	11.1%	6.5%	a	2.6%
Maine	100.0%	17.4%	a	a	a	19.4%	12.2%	a	a
New Hampshire	100.0%	8.8%	a	a	a	12.9%	9.2%	a	a
Vermont	100.0%	a	a	a	a	a	a	a	a
Massachusetts	100.0%	12.9%	2.4%	6.5%	3.1%	9.6%	5.3%	a	2.5%
Rhode Island	100.0%	11.8%	a	a	a	12.0%	a	a	a
Connecticut	100.0%	8.6%	a	4.2%	a	9.6%	5.7%	a	a
Middle Atlantic	100.0%	17.6%	2.8%	8.9%	5.0%	11.4%	6.4%	1.0%	2.7%
New York	100.0%	21.2%	3.2%	11.7%	5.8%	12.0%	6.7%	1.3%	3.1%
New Jersey	100.0%	10.9%	1.6%	5.2%	3.1%	9.6%	5.2%	a	2.5%
Pennsylvania	100.0%	16.3%	3.1%	6.9%	5.0%	11.6%	6.8%	0.9%	2.3%
East North Central	100.0%	18.5%	3.0%	8.9%	0.0%	13.1%	7.9%	0.9%	3.0%
Ohio	100.0%	17.4%	2.3%	7.4%	6.1%	13.0%	8.2%	a	2.7%
Indiana	100.0%	17.3%	3.9%	a	8.5%	16.3%	10.9%	a	3.9%
Illinois	100.0%	21.0%	3.3%	10.6%	5.9%	12.0%	7.4%	a	2.8%
Michigan	100.0%	19.5%	2.9%	11.6%	3.6%	12.4%	7.1%	2.0%	2.4%
Wisconsin	100.0%	14.5%	2.1%	9.2%	2.3%	13.9%	7.0%	a	3.9%
West North Central	100.0%	18.1%	3.6%	6.3%	5.7%	14.3%	8.5%	a	3.1%
Minnesota	100.0%	14.7%	a	6.6%	3.4%	12.2%	7.7%	a	3.0%
Iowa	100.0%	23.9%	5.5%	9.4%	6.5%	11.1%	6.6%	a	a
Missouri	100.0%	18.2%	4.3%	6.4%	6.0%	17.5%	10.1%	a	4.5%
North Dakota	100.0%	17.6%	a	a	a	a	a	a	a
South Dakota	100.0%	20.4%	a	a	a	18.3%	a	a	a
Nebraska	100.0%	17.0%	a	a	6.7%	16.7%	10.0%	a	a
Kansas	100.0%	17.8%	a	4.4%	7.3%	12.4%	7.3%	a	a
South Atlantic	100.0%	18.9%	3.8%	5.3%	8.0%	15.1%	8.5%	0.7%	4.0%
Delaware	100.0%	17.5%	a	a	a	a	a	a	a
Maryland	100.0%	12.3%	a	4.4%	4.8%	9.9%	4.9%	a	3.1%
DC	100.0%	26.1%	a	a	a	17.4%	a	a	a
Virginia	100.0%	13.7%	2.6%	4.1%	5.9%	11.9%	7.5%	a	3.0%
West Virginia	100.0%	30.7%	7.3%	10.5%	9.4%	20.4%	10.3%	a	5.9%
North Carolina	100.0%	17.4%	4.0%	3.6%	7.5%	16.6%	10.6%	a	3.2%
South Carolina	100.0%	19.3%	4.3%	6.7%	6.7%	16.4%	9.7%	a	3.9%
Georgia	100.0%	21.9%	4.3%	7.5%	7.7%	15.0%	8.2%	a	4.5%
Florida	100.0%	21.0%	4.1%	4.2%	10.9%	16.5%	1.3%	a	4.8%
East South Central	100.0%	26.4%	5.5%	6.3%	12.0%	18.4%	11.0%	0.6%	4.5%
Kentucky	100.0%	27.1%	5.9%	5.7%	13.6%	15.8%	a	a	3.9%
Tennessee	100.0%	23.3%	3.6%	6.5%	9.7%	20.2%	2.3%	a	5.5%
Alabama	100.0%	25.9%	6.9%	a	11.0%	17.6%	a	a	4.6%
Mississippi	100.0%	32.2%	6.1%	7.7%	15.5%	20.2%	a	a	a
West South Central	100.0%	22.6%	4.8%	4.4%	11.6%	15.8%	8.6%	0.5%	4.8%
Arkansas	100.0%	31.3%	5.9%	7.9%	15.2%	15.9%	a	a	a
Louisiana	100.0%	22.9%	5.3%	a	11.5%	16.1%	a	a	4.1%
Oklahoma	100.0%	20.4%	2.9%	3.5%	11.6%	16.1%	a	a	6.2%
Texas	100.0%	21.7%	4.9%	4.4%	11.0%	15.7%	1.3%	a	5.0%
Mountain	100.0%	17.0%	3.9%	3.3%	7.5%	15.4%	8.1%	a	4.5%
Montana	100.0%	21.9%	a	a	a	16.8%	a	a	a
Idaho	100.0%	20.9%	a	a	a	19.5%	11.8%	a	a
Wyoming	100.0%	a	a	a	a	a	a	a	a
Colorado	100.0%	12.2%	a	2.9%	6.3%	10.4%	4.5%	a	4.1%
New Mexico	100.0%	25.6%	a	6217.2%	10.3%	18.3%	8.7%	a	a
Arizona	100.0%	15.0%	3.1%	a	7.8%	16.2%	7.6%	a	4.5%
Utah	100.0%	17.4%	6.8%	a	a	18.6%	12.4%	a	a
Nevada	100.0%	19.3%	a	a	9.5%	16.4%	9.7%	a	a
Pacific	100.0%	16.1%	3.0%	6.7%	7.3%	13.3%	6.5%	1.5%	4.2%
Washington	100.0%	16.0%	2.6%	6.5%	5.6%	14.3%	8.4%	a	4.0%
Oregon	100.0%	17.5%	3.4%	a	8.3%	15.3%	8.2%	a	a
California	100.0%	16.7%	3.0%	7.2%	7.6%	13.0%	6.0%	1.7%	4.4%
Alaska	100.0%	a	a	a	a	a	a	a	a
Hawaii	100.0%	15.0%	a	a	a	12.8%	a	a	a

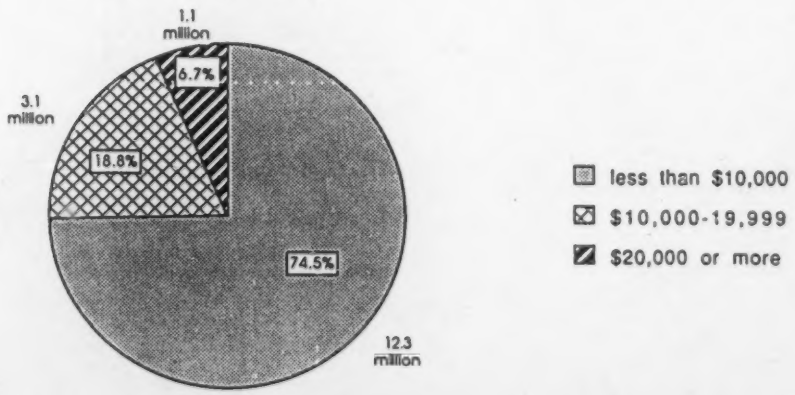
Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.
a--Number too small to be statistically reliable.

Workers Age 18-64, by Selected Sources of Health Insurance Coverage and Personal Earnings, 1985

Personal Earnings	Total	Insured Population: Private & Public				No Health Insurance Coverage
		Total	Employer-provided			
			Total	Direct	Indirect	
		(In millions)				
Total	112.4	95.9	85.1	68.4	16.7	16.5
less than $10,000	44.2	31.9	23.8	11.5	12.3	12.3
$10,000-19,999	31.0	27.9	26.4	23.5	2.9	3.1
$20,000-29,999	19.6	18.9	18.3	17.4	0.9	0.7
$30,000-39,999	9.9	9.7	9.4	9.1	0.3	0.2
$40,000 or more	7.7	7.5	7.2	7.0	0.2	0.2
		(percent within source of coverage groups)				
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
less than $10,000	39.3%	33.3%	28.0%	16.8%	73.6%	74.5%
$10,000-19,999	27.6%	29.1%	31.0%	34.3%	17.6%	18.8%
$20,000-29,999	17.4%	19.7%	21.5%	25.4%	5.6%	4.2%
$30,000-39,999	8.8%	10.1%	11.0%	13.3%	1.9%	1.2%
$40,000 or more	6.9%	7.8%	8.5%	10.2%	1.3%	1.2%
		(percent within income groups)				
Total	100.0%	85.3%	75.7%	60.9%	14.9%	14.7%
less than $10,000	100.0%	72.2%	53.8%	26.0%	27.8%	27.8%
$10,000-19,999	100.0%	90.0%	85.2%	75.8%	9.4%	10.0%
$20,000-29,999	100.0%	96.4%	93.4%	88.8%	4.6%	3.6%
$30,000-39,999	100.0%	98.0%	94.9%	91.9%	3.0%	2.0%
$40,000 or more	100.0%	97.4%	93.5%	90.9%	2.6%	2.6%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Workers Age 18-64 Without Health Insurance Coverage by Personal Earnings, 1985



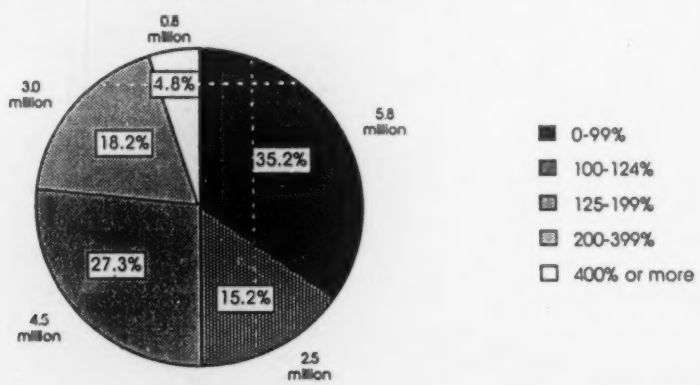
Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Workers Age 18-64 by Selected Sources of Health Insurance Coverage and Hourly Earnings as a Percent of the Federal Minimum Wage, 1985

Hourly Wages as a Percent of Minimum Wage	Total	Insured Population: Private & Public							No Health Insurance Coverage
		Total Insured	Private				Public		
			Total Private	Employer-provided			Total Public	Medicaid	
				Total	Direct	Indirect			
	(In millions)								
Total	112.4	95.9	92.6	85.1	68.4	16.7	6.6	2.6	16.5
0-99%	18.3	12.5	11.1	8.3	3.2	5.0	2.0	1.1	5.8
100-124%	8.8	6.3	5.8	5.0	2.7	2.3	0.9	0.5	2.5
125-199%	24.5	20.0	19.3	17.6	13.2	4.4	1.5	0.6	4.5
200-399%	40.6	37.6	37.1	35.7	31.7	3.9	1.6	0.4	3.0
400% or more	20.2	19.4	19.3	18.6	17.5	1.1	0.7	0.1	0.8
	(percents within source of coverage groups)								
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
0-99%	16.3%	13.0%	12.0%	9.8%	4.7%	29.9%	30.3%	42.3%	35.2%
100-124%	7.8%	6.6%	6.3%	5.9%	3.9%	13.8%	13.6%	19.2%	15.2%
125-199%	21.8%	20.9%	20.8%	20.7%	19.3%	26.3%	22.7%	23.1%	27.3%
200-399%	36.1%	39.2%	40.1%	42.0%	46.3%	23.4%	24.2%	15.4%	18.2%
400% or more	18.0%	20.2%	20.8%	21.9%	25.6%	6.6%	10.6%	3.8%	4.8%
	(percents within minimum wage groups)								
Total	100.0%	85.3%	82.4%	75.8%	60.9%	14.9%	5.9%	2.4%	14.7%
0-99%	100.0%	68.3%	60.7%	45.3%	17.5%	27.6%	10.7%	5.7%	31.7%
100-124%	100.0%	71.6%	65.6%	56.4%	30.7%	25.7%	9.8%	5.3%	28.3%
125-199%	100.0%	81.6%	78.8%	71.2%	54.1%	17.9%	6.3%	2.6%	18.3%
200-399%	100.0%	92.6%	91.5%	87.8%	78.1%	9.7%	3.9%	0.9%	7.4%
400% or more	100.0%	96.0%	95.5%	92.1%	86.9%	5.3%	3.5%	0.6%	3.8%

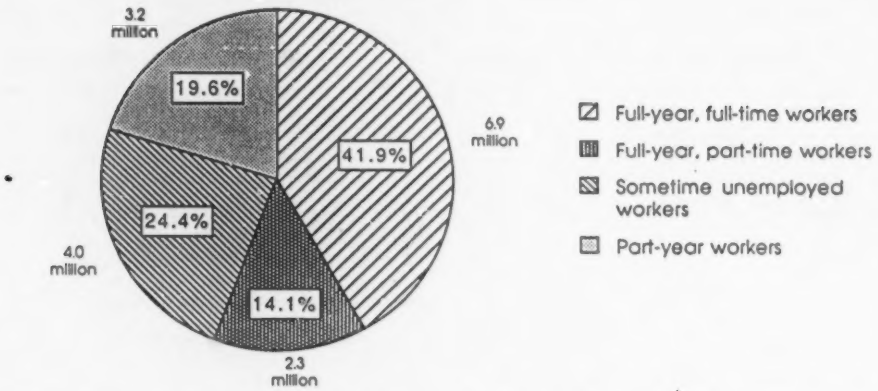
Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Workers Age 18-64 Without Health Insurance Coverage by Hourly Earnings as a Percent of the Federal Minimum Wage, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Workers Age 18-64 Without Health Insurance Coverage by Own Work Status, 1985



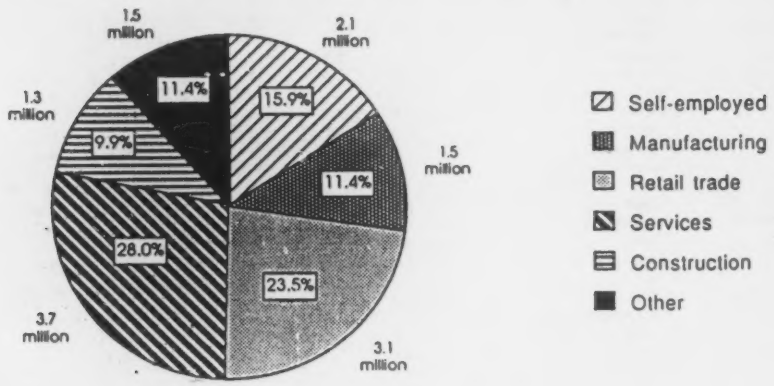
Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Full-year Workers Age 18-64, by Selected Sources of Health Insurance Coverage and Own Unemployment Experience, 1985

Unemployment Experience	Total	Insured Population: Private and Public				No Health Insurance Coverage
		Total	Employer-provided			
			Total	Direct	Indirect	
Total	98.5	85.2	77.1	65.5	11.6	13.3
Never Unemployed	84.7	75.4	69.1	59.3	9.7	9.3
Unemployed 1-4 weeks	2.2	1.7	1.5	1.2	0.3	0.5
Unemployed 5-12 weeks	4.1	3.1	2.7	2.1	0.5	1.0
Unemployed 13+ weeks	7.5	5.0	3.9	2.8	1.0	2.5
(percent within source of coverage groups)						
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Never Unemployed	86.0%	88.5%	89.6%	90.6%	83.8%	69.9%
Unemployed 1-4 weeks	2.2%	2.0%	1.9%	1.8%	2.6%	3.8%
Unemployed 5-12 weeks	4.2%	3.6%	3.5%	3.3%	4.7%	7.5%
Unemployed 13+ weeks	7.6%	5.9%	5.1%	4.3%	8.9%	18.8%
(percent within unemployment categories)						
Total	100.0%	86.5%	78.3%	66.5%	11.8%	13.5%
Never Unemployed	100.0%	89.0%	81.6%	70.0%	11.5%	11.0%
Unemployed 1-4 weeks	100.0%	77.3%	68.2%	54.5%	13.6%	22.7%
Unemployed 5-12 weeks	100.0%	75.6%	65.9%	51.2%	12.2%	24.4%
Unemployed 13+ weeks	100.0%	66.7%	52.0%	37.3%	13.3%	33.3%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population

Full Year Workers Age 18-64 Without Health Insurance Coverage
by Industry of Primary Employment, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Workers Age 18-64 with Selected Sources of Coverage by Industry of Primary Employment and Age, 1985 (in millions)

	Total	Worker Age					
		18-20	21-24	25-29	30-44	45-54	55+
Total	112.4	7.9	13.3	17.5	43.3	17.6	12.7
Self-employed	9.7	a	0.3	1	4.4	2.2	1.8
Total Employer-based coverage	5	a	0.1	0.4	2.4	1.1	0.8
Direct	2.8	a	a	0.2	1.3	0.7	0.6
Indirect	2.1	a	a	0.2	1.1	0.5	0.3
No Coverage	2.3	a	0.1	0.3	1	0.5	0.4
Mining	1.1	a	0.1	0.2	0.5	0.1	0.1
Total Employer-based coverage	0.9	a	0.1	0.2	0.4	0.1	a
Direct	0.9	a	a	0.2	0.4	0.1	a
Indirect	a	a	a	a	a	a	a
No Coverage	0.1	a	a	a	a	a	a
Construction	6.3	0.5	1	1.1	2.3	0.9	0.6
Total Employer-based coverage	4.2	0.3	0.5	0.7	1.6	0.7	0.5
Direct	3.5	0.1	0.4	0.5	1.4	0.6	0.4
Indirect	0.7	0.2	a	0.1	0.2	0.1	a
No Coverage	1.5	0.1	0.4	0.3	0.5	0.1	a
Manufacturing	21.9	0.9	2.3	3.5	8.6	4	2.7
Total Employer-based coverage	19.3	0.6	1.7	3	7.8	3.6	2.5
Direct	17.9	0.3	1.6	2.9	7.3	3.4	2.4
Indirect	1.4	0.3	0.2	0.2	0.5	0.2	0.1
No Coverage	1.9	0.2	0.4	0.4	0.6	0.2	0.1
Transportation, Communication & Other Public Utilities	7.6	0.2	0.6	1.1	3.5	1.3	0.9
Total Employer-based coverage	6.6	0.1	0.4	0.9	3.2	1.2	0.8
Direct	6.1	a	0.4	0.9	3	1.1	0.7
Indirect	0.5	a	a	a	0.2	0.1	a
No Coverage	0.6	a	0.1	0.1	0.2	0.1	a
Wholesale trade	4.1	0.2	0.5	0.7	1.6	0.6	0.5
Total Employer-based coverage	3.4	0.2	0.3	0.6	1.5	0.5	0.4
Direct	3	a	0.3	0.6	1.3	0.4	0.3
Indirect	0.4	0.1	a	a	0.2	a	a
No Coverage	0.4	a	0.1	0.1	0.1	a	a
Retail trade	17.6	3.5	3.5	2.9	4.8	1.6	1.3
Total Employer-based coverage	11.2	2.1	1.8	1.8	3.4	1.2	0.9
Direct	7	0.5	1.2	1.4	2.4	0.8	0.7
Indirect	4.2	1.7	0.5	0.4	1.1	0.3	0.2
No Coverage	4.1	0.8	1.3	0.7	0.8	0.3	0.1
Finance, Insurance & Real Estate	6.6	0.3	0.8	1.3	2.5	1	0.7
Total Employer-based coverage	5.7	0.2	0.7	1.2	2.2	0.8	0.5
Direct	4.8	0.1	0.6	1.1	1.9	0.7	0.5
Indirect	0.9	0.1	0.1	0.1	0.3	0.2	a
No Coverage	0.5	a	0.1	0.1	0.2	a	a
Business & Repair Services	5.3	0.4	0.9	1	2	0.6	0.4
Total Employer-based coverage	3.5	0.2	0.5	0.7	1.5	0.4	0.2
Direct	2.6	a	0.4	0.6	1.1	0.3	0.2
Indirect	0.9	0.2	0.1	0.1	0.4	0.1	a
No Coverage	1.2	0.1	0.3	0.3	0.3	0.1	a
Personal Services	3.7	0.4	0.6	0.5	1.1	0.6	0.5
Total Employer-based coverage	1.6	0.2	0.3	0.3	0.6	0.3	0.2
Direct	1	a	0.1	0.2	0.3	0.1	0.1
Indirect	0.6	0.2	0.1	0.1	0.3	0.1	a
No Coverage	1.2	0.1	0.2	0.2	0.3	0.2	0.2
Entertainment & Recreation Services	1.3	0.3	0.2	0.2	0.3	0.1	0.1
Total Employer-based coverage	0.7	0.2	0.1	0.1	0.2	0.1	a
Direct	0.4	a	a	0.1	0.2	a	a
Indirect	0.3	0.2	a	a	a	a	a
No Coverage	0.3	a	0.1	a	a	a	a
Profecsional and Related Services	21.9	1	2.2	3.2	9.3	3.8	2.5
Total Employer-based coverage	17.9	0.6	1.3	2.6	8.1	3.3	2
Direct	14	0.2	1	2.3	6.2	2.6	1.8
Indirect	3.9	0.4	0.3	0.4	1.9	0.7	0.2
No Coverage	2.2	0.2	0.6	0.3	0.6	0.2	0.2
Public Administration	5.4	0.2	0.4	0.7	2.4	1	0.7
Total Employer-based coverage	4.8	0.1	0.3	0.6	2.2	1	0.6
Direct	4.3	a	0.3	0.6	2	0.9	0.5
Indirect	0.5	0.1	a	a	0.2	0.1	a
No Coverage	0.3	a	0.1	a	0.1	a	a

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

Percent of Workers Age 18-64 with Selected Sources of Coverage by Industry of Primary Employment and Age, 1985

		Worker Age					
	Total	18-20	21-24	25-29	30-44	45-54	55+
Total	100.0%	7.0%	11.8%	15.6%	38.5%	15.7%	11.3%
Self-employed	100.0%	a	3.1%	10.3%	45.4%	22.7%	18.6%
Total Employer-based coverage	100.0%	a	2.0%	8.0%	48.0%	22.0%	16.0%
Direct	100.0%	a	a	7.1%	46.4%	25.0%	21.4%
Indirect	100.0%	a	a	9.5%	52.4%	23.8%	14.3%
No Coverage	100.0%	a	4.3%	13.0%	43.5%	21.7%	17.4%
Mining	100.0%	a	9.1%	18.2%	45.5%	9.1%	9.1%
Total Employer-based coverage	100.0%	a	11.1%	22.2%	44.4%	11.1%	a
Direct	100.0%	a	a	22.2%	44.4%	11.1%	a
Indirect	a	a	a	a	a	a	a
No Coverage	100.0%	a	a	a	a	a	a
Construction	100.0%	7.9%	15.9%	17.5%	36.5%	14.3%	9.5%
Total Employer-based coverage	100.0%	7.1%	11.9%	16.7%	38.1%	16.7%	11.9%
Direct	100.0%	2.9%	11.4%	17.1%	40.0%	17.1%	11.4%
Indirect	100.0%	28.6%	a	14.3%	28.6%	14.3%	a
No Coverage	100.0%	6.7%	26.7%	20.0%	33.3%	6.7%	a
Manufacturing	100.0%	4.1%	10.5%	16.0%	39.3%	18.3%	12.3%
Total Employer-based coverage	100.0%	3.1%	8.8%	15.5%	40.4%	18.7%	13.0%
Direct	100.0%	1.7%	8.9%	16.2%	40.8%	19.0%	13.4%
Indirect	100.0%	21.4%	14.3%	14.3%	35.7%	14.3%	7.1%
No Coverage	100.0%	10.5%	21.1%	21.1%	31.6%	10.5%	5.3%
Transportation, Communication & Other Public Utilities	100.0%	2.6%	7.9%	14.5%	46.1%	17.1%	11.8%
Total Employer-based coverage	100.0%	1.5%	6.1%	13.6%	48.5%	18.2%	12.1%
Direct	100.0%	a	6.6%	14.8%	49.2%	18.0%	11.5%
Indirect	100.0%	a	a	a	40.0%	20.0%	a
No Coverage	100.0%	a	16.7%	16.7%	33.3%	16.7%	a
Wholesale trade	100.0%	4.9%	12.2%	17.1%	39.0%	14.6%	12.2%
Total Employer-based coverage	100.0%	5.9%	8.8%	17.6%	44.1%	14.7%	11.8%
Direct	100.0%	a	10.0%	20.0%	43.3%	13.3%	10.0%
Indirect	100.0%	25.0%	a	a	50.0%	a	a
No Coverage	100.0%	a	25.0%	25.0%	25.0%	a	a
Retail trade	100.0%	19.9%	19.9%	16.5%	27.3%	9.1%	7.4%
Total Employer-based coverage	100.0%	18.8%	16.1%	16.1%	30.4%	10.7%	8.0%
Direct	100.0%	7.1%	17.1%	20.0%	34.3%	11.4%	10.0%
Indirect	100.0%	40.5%	11.9%	9.5%	26.2%	7.1%	4.8%
No Coverage	100.0%	19.5%	31.7%	17.1%	19.5%	7.3%	2.4%
Finance, Insurance & Real Estate	100.0%	4.5%	12.1%	19.7%	37.9%	15.2%	10.6%
Total Employer-based coverage	100.0%	3.5%	12.3%	21.1%	38.6%	14.0%	8.8%
Direct	100.0%	2.1%	12.5%	22.9%	39.6%	14.6%	10.4%
Indirect	100.0%	11.1%	11.1%	11.1%	33.3%	22.2%	a
No Coverage	100.0%	a	20.0%	20.0%	40.0%	a	a
Business & Repair Services	100.0%	7.5%	17.0%	18.9%	37.7%	11.3%	7.5%
Total Employer-based coverage	100.0%	5.7%	14.3%	20.0%	42.9%	11.4%	5.7%
Direct	100.0%	a	15.4%	23.1%	42.3%	11.5%	7.7%
Indirect	100.0%	22.2%	11.1%	11.1%	44.4%	11.1%	a
No Coverage	100.0%	8.3%	25.0%	25.0%	25.0%	8.3%	a
Personal Services	100.0%	10.8%	16.2%	13.5%	29.7%	16.2%	13.5%
Total Employer-based coverage	100.0%	11.1%	16.7%	16.7%	33.3%	16.7%	11.1%
Direct	100.0%	a	10.0%	20.0%	30.0%	10.0%	10.0%
Indirect	100.0%	25.0%	12.5%	12.5%	37.5%	12.5%	a
No Coverage	100.0%	8.3%	16.7%	16.7%	25.0%	16.7%	16.7%
Entertainment & Recreation Services	100.0%	23.1%	15.4%	15.4%	23.1%	7.7%	7.7%
Total Employer-based coverage	100.0%	28.6%	14.3%	14.3%	28.6%	14.3%	a
Direct	100.0%	a	a	25.0%	50.0%	a	a
Indirect	100.0%	66.7%	a	a	a	a	a
No Coverage	100.0%	a	33.3%	a	a	a	a
Professional and Related Services	100.0%	4.6%	10.0%	14.6%	42.5%	17.4%	11.4%
Total Employer-based coverage	100.0%	3.4%	7.3%	14.5%	45.3%	18.4%	11.2%
Direct	100.0%	1.4%	7.1%	16.4%	44.3%	18.6%	12.9%
Indirect	100.0%	10.3%	7.7%	10.3%	48.7%	17.9%	5.1%
No Coverage	100.0%	9.1%	27.3%	13.6%	27.3%	9.1%	9.1%
Public Administration	100.0%	3.7%	7.4%	13.0%	44.4%	18.5%	13.0%
Total Employer-based coverage	100.0%	2.1%	6.3%	12.5%	45.8%	20.8%	12.5%
Direct	100.0%	a	7.0%	14.0%	46.5%	20.9%	11.6%
Indirect	100.0%	20.0%	a	a	40.0%	20.0%	a
No Coverage	100.0%	a	33.3%	a	33.3%	a	a

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

Percent of Workers Age 18-64 with Selected Sources of Health Insurance Coverage by Industry of Primary Employment and Number of Employers During the Year, 1988

	Total	Employer-based			No Health Insurance Coverage
		Total	Direct	Indirect	
Total	100.0%	75.7%	60.9%	14.9%	14.7%
1 employer	100.0%	77.7%	63.3%	14.3%	12.9%
2 employers	100.0%	66.2%	51.5%	14.7%	20.6%
3 employers	100.0%	54.3%	37.0%	13.0%	21.7%
Self-employed	100.0%	51.5%	28.9%	21.6%	23.7%
1 employer	100.0%	51.7%	29.2%	22.5%	22.5%
2 employers	100.0%	50.0%	33.3%	16.7%	33.3%
3 employers	100.0%	a	a	a	a
Mining	100.0%	81.8%	81.8%	a	9.1%
1 employer	100.0%	88.9%	88.9%	a	a
2 employers	100.0%	100.0%	100.0%	a	a
3 employers	100.0%	a	a	a	a
Construction	100.0%	66.7%	55.6%	11.1%	23.8%
1 employer	100.0%	68.9%	60.0%	11.1%	20.0%
2 employers	100.0%	54.5%	45.5%	9.1%	27.3%
3 employers	100.0%	57.1%	42.9%	a	28.6%
Manufacturing	100.0%	88.1%	81.7%	6.4%	8.2%
1 employer	100.0%	89.6%	83.9%	5.7%	7.3%
2 employers	100.0%	76.2%	66.7%	9.5%	14.3%
3 employers	100.0%	66.7%	66.7%	16.7%	16.7%
Transportation, Communication & Other Public Utilities	100.0%	86.8%	80.3%	6.6%	7.9%
1 employer	100.0%	89.6%	83.6%	6.0%	7.5%
2 employers	100.0%	71.4%	71.4%	a	14.3%
3 employers	100.0%	50.0%	50.0%	a	a
Wholesale trade	100.0%	82.9%	73.2%	9.8%	9.8%
1 employer	100.0%	85.3%	76.5%	8.8%	8.8%
2 employers	100.0%	80.0%	80.0%	a	20.0%
3 employers	100.0%	a	a	a	a
Retail trade	100.0%	63.6%	39.8%	23.9%	23.3%
1 employer	100.0%	65.9%	42.2%	23.7%	21.5%
2 employers	100.0%	60.0%	33.3%	26.7%	26.7%
3 employers	100.0%	54.5%	27.3%	27.3%	36.4%
Finance, Insurance & Real Estate	100.0%	86.4%	72.7%	13.6%	7.6%
1 employer	100.0%	85.7%	73.2%	12.5%	7.1%
2 employers	100.0%	87.5%	75.0%	12.5%	12.5%
3 employers	100.0%	100.0%	50.0%	a	a
Business & Repair Services	100.0%	66.0%	49.1%	17.0%	22.6%
1 employer	100.0%	70.0%	52.5%	17.5%	20.0%
2 employers	100.0%	55.6%	33.3%	11.1%	33.3%
3 employers	100.0%	50.0%	25.0%	a	25.0%
Personal Services	100.0%	48.6%	27.0%	21.6%	32.4%
1 employer	100.0%	51.7%	27.6%	24.1%	31.0%
2 employers	100.0%	40.0%	20.0%	20.0%	40.0%
3 employers	100.0%	50.0%	a	a	50.0%
Entertainment & Recreation Services	100.0%	53.8%	30.8%	23.1%	23.1%
1 employer	100.0%	55.6%	33.3%	22.2%	22.2%
2 employers	100.0%	50.0%	50.0%	a	a
3 employers	100.0%	a	a	a	a
Professional and Related Services	100.0%	81.7%	64.4%	17.8%	10.0%
1 employer	100.0%	83.3%	65.6%	17.2%	8.6%
2 employers	100.0%	73.1%	57.7%	19.2%	15.4%
3 employers	100.0%	71.4%	57.1%	28.6%	14.3%
Public Administration	100.0%	88.9%	79.6%	9.3%	5.6%
1 employer	100.0%	89.8%	79.6%	8.2%	4.1%
2 employers	100.0%	80.0%	60.0%	a	a
3 employers	100.0%	a	a	a	a

Source: Employee Benefit Research Institute tabulations of the March 1989 Current Population Survey.

a--Number too small to be statistically reliable.

Workers Age 18-64 with Selected Sources of Health Insurance Coverage by Industry of Primary Employment and Number of Employers During the Year, 1985 (in millions)

	Total	Employer-based			No Health Insurance Coverage
		Total	Direct	Indirect	
Total	112.4	85.1	68.4	16.7	16.5
1 employer	94.0	73.0	59.5	13.4	12.1
2 employers	13.6	9.0	7.0	2.0	2.8
3 employers	4.6	2.5	1.7	0.6	1.0
Self-employed	9.7	5.0	2.8	2.1	2.3
1 employer	8.9	4.6	2.6	2.0	2.0
2 employers	0.6	0.3	0.2	0.1	0.2
3 employers	0.2	a	a	a	a
Mining	1.1	0.9	0.9	a	0.1
1 employer	0.9	0.8	0.8	a	a
2 employers	0.1	0.1	0.1	a	a
3 employers	a	a	a	a	a
Construction	6.3	4.2	3.5	0.7	1.5
1 employer	4.5	3.1	2.7	0.5	0.9
2 employers	1.1	0.6	0.5	0.1	0.3
3 employers	0.7	0.4	0.3	a	0.2
Manufacturing	21.9	19.3	17.9	1.4	1.8
1 employer	19.2	17.2	16.1	1.1	1.4
2 employers	2.1	1.6	1.4	0.2	0.3
3 employers	0.6	0.4	0.4	0.1	0.1
Transportation, Communication & Other Public Utilities	7.6	6.6	6.1	0.5	0.6
1 employer	6.7	6.0	5.6	0.4	0.5
2 employers	0.7	0.5	0.5	a	0.1
3 employers	0.2	0.1	0.1	a	a
Wholesale trade	4.1	3.4	3.0	0.4	0.4
1 employer	3.4	2.9	2.6	0.3	0.3
2 employers	0.5	0.4	0.4	a	0.1
3 employers	0.1	a	a	a	a
Retail trade	17.6	11.2	7.0	4.2	4.1
1 employer	13.5	8.9	5.7	3.2	2.9
2 employers	3.0	1.8	1.0	0.8	0.8
3 employers	1.1	0.6	0.3	0.3	0.4
Finance, Insurance & Real Estate	6.6	5.7	4.8	0.9	0.5
1 employer	5.6	4.8	4.1	0.7	0.4
2 employers	0.8	0.7	0.6	0.1	0.1
3 employers	0.2	0.2	0.1	a	a
Business & Repair Services	5.3	3.5	2.6	0.9	1.2
1 employer	4.0	2.8	2.1	0.7	0.8
2 employers	0.9	0.5	0.3	0.1	0.3
3 employers	0.4	0.2	0.1	a	0.1
Personal Services	3.7	1.8	1.0	0.8	1.2
1 employer	2.9	1.5	0.8	0.7	0.9
2 employers	0.5	0.2	0.1	0.1	0.2
3 employers	0.2	0.1	a	a	0.1
Entertainment & Recreation Services	1.3	0.7	0.4	0.3	0.3
1 employer	0.9	0.5	0.3	0.2	0.2
2 employers	0.2	0.1	0.1	a	a
3 employers	0.1	a	a	a	a
Professional and Related Services	21.9	17.9	14.1	3.9	2.2
1 employer	18.6	15.5	12.2	3.2	1.6
2 employers	2.6	1.9	1.5	0.5	0.4
3 employers	0.7	0.5	0.4	0.2	0.1
Public Administration	5.4	4.8	4.3	0.5	0.3
1 employer	4.9	4.4	3.9	0.4	0.2
2 employers	0.5	0.3	0.3	a	a
3 employers	0.1	a	a	a	a

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a–Number too small to be statistically reliable.

Children Age 18 or Under Without Health Insurance Coverage by Selected Sources of Health Insurance Coverage of the Family Head and Family Income as a Percent of Poverty, 1985

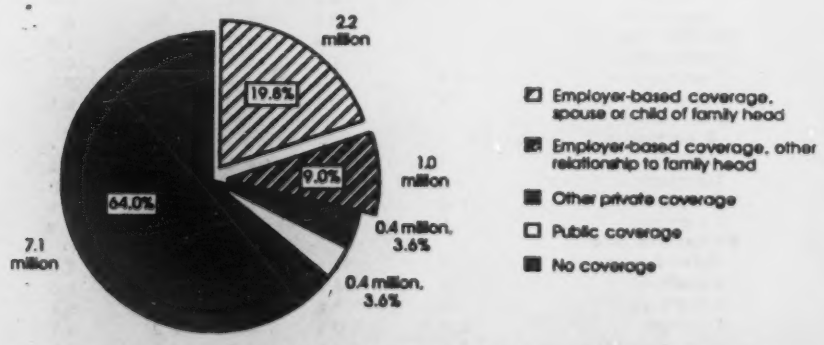
Source of Coverage for Family Head	Total	Family Income as a Percent of Poverty				
		0-99%	100-124%	125-199%	200-399%	400+%
				(in millions)		
Total	11.1	4.3	1.1	2.5	2.4	0.8
Employer-provided	3.2	0.4	0.2	0.8	1.2	0.5
Other private	0.4	0.1	a	0.1	0.1	a
Medicaid	0.2	0.2	a	a	a	a
Other public	0.2	0.1	a	a	a	a
No health insurance	7.1	3.5	0.8	1.5	1.1	0.3
				(percent within poverty income levels)		
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Employer-provided	28.9%	10.1%	22.3%	34.3%	49.7%	61.2%
Other private	3.5%	3.0%	a	4.1%	3.4%	a
Medicaid	1.7%	3.9%	a	a	a	a
Other public	1.9%	2.8%	a	a	a	a
No health insurance	64.1%	80.3%	69.2%	60.6%	46.2%	33.9%
				(percent within family head insurance coverage groups)		
Total	100.0%	39.0%	10.0%	22.3%	22.0%	6.8%
Employer-provided	100.0%	13.6%	7.7%	26.4%	37.9%	14.4%
Other private	100.0%	33.5%	a	25.9%	21.5%	a
Medicaid	100.0%	91.5%	a	a	a	a
Other public	100.0%	58.6%	a	a	a	a
No health insurance	100.0%	48.8%	10.8%	21.0%	15.8%	3.6%

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

a--Number too small to be statistically reliable.

NOTE: Data do not reflect coverage from more than one source. Children are allocated sequentially to the family head's coverage categories as follows: 1. Employer-provided, 2. Other private, 3. Medicaid, 4. Other public, and, finally, 5. No health insurance.

Children Age 18 or Under Without Health Insurance Coverage by Selected Sources of Health Insurance Coverage of the Family Head and Relationship to Family Head, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

NOTE: Data do not reflect coverage from more than one source. Children are allocated sequentially to the family head's coverage category as follow: 1. Employer-based, 2. Other private, 3. Public, 4. No health insurance.

Children Under Age 18 Without Health Insurance by Family Type and Poverty Status, and Sex and Work Status of the Family Head, 1985

	Total	Family Income as a Percent of Poverty			
		0-99%	100-124%	125-199%	200% +
		(in millions)			
All Uninsured Children	10.8	4.2	1.1	2.4	3.1
Family Type and Work Status					
Spouse Present	5.9	1.8	0.6	1.4	2
Family Head is:					
Full-year worker	5.2	1.4	0.6	1.3	1.9
Part-year worker	0.3	0.1	a	0.1	a
Nonworker	0.3	0.2	a	a	a
Spouse Absent	4.9	2.4	0.4	1.0	1.1
Family Head is:					
Male	1.0	0.3	0.1	0.2	0.3
Full-year worker	0.7	0.2	a	0.2	0.3
Part-year worker	0.1	0.1	a	a	a
Nonworker	0.1	a	a	a	a
Female	4.0	2.1	0.3	0.8	0.8
Full-year worker	2.5	0.9	0.3	0.6	0.7
Part-year worker	0.5	0.4	a	a	a
Nonworker	1.0	0.9	a	a	a
		(percents within family status groups)			
All Uninsured Children	100.0%	100.0%	100.0%	100.0%	100.0%
Family Type and Work Status					
Spouse Present	54.6%	42.9%	54.5%	58.3%	64.5%
Family Head is:					
Full-year worker	48.1%	33.3%	54.5%	54.2%	61.3%
Part-year worker	2.8%	2.4%	a	4.2%	a
Nonworker	2.8%	4.8%	a	a	a
Spouse Absent	45.4%	57.1%	36.4%	41.7%	35.5%
Family Head is:					
Male	9.3%	7.1%	9.1%	8.3%	9.7%
Full-year worker	6.5%	4.8%	a	8.3%	9.7%
Part-year worker	0.9%	2.4%	a	a	a
Nonworker	0.9%	a	a	a	a
Female	37.0%	50.0%	27.3%	33.3%	25.8%
Full-year worker	23.1%	21.4%	27.3%	25.0%	22.6%
Part-year worker	4.6%	9.5%	a	a	a
Nonworker	9.3%	21.4%	a	a	a
		(percents within poverty status groups)			
All Uninsured Children	100.0%	38.9%	10.2%	22.2%	28.7%
Family Type and Work Status					
Spouse Present	100.0%	30.5%	10.2%	23.7%	33.9%
Family Head is:					
Full-year worker	100.0%	26.9%	11.5%	25.0%	36.5%
Part-year worker	100.0%	33.3%	a	33.3%	a
Nonworker	100.0%	66.7%	a	a	a
Spouse Absent	100.0%	49.0%	8.2%	20.4%	22.4%
Family Head is:					
Male	100.0%	30.0%	10.0%	20.0%	30.0%
Full-year worker	100.0%	28.6%	a	28.6%	42.9%
Part-year worker	100.0%	100.0%	a	a	a
Nonworker	100.0%	a	a	a	a
Female	100.0%	52.5%	7.5%	20.0%	20.0%
Full-year worker	100.0%	36.0%	12.0%	24.0%	28.0%
Part-year worker	100.0%	80.0%	a	a	a
Nonworker	100.0%	90.0%	a	a	a

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.
a--Number too small to be statistically reliable.

Appendix 1: Glossary of Terms

The Current Population Survey is conducted by the U.S. Bureau of the Census. Each March, a supplement is conducted to collect information on the U.S. population with respect to employment, income and health insurance coverage. The health insurance data provide information on coverage from each specific source; people may, however, obtain insurance coverage from more than one source.

Of 71,000 households assigned to be interviewed, about 58,000 households are interviewed each month. An estimated 13,000 households were unable to be interviewed. The interviewed households include approximately 122,000 persons age 14 or older; information is also obtained for approximately 34,000 children ages 0-13 in these households. In addition, a sample of 2,500 hispanic households is added to the March CPS supplement. Respondents to the March CPS supplement are weighted to represent the total noninstitutionalized U.S. population.

The **Employee Benefit Research Institute (EBRI)** tabulates the public-use data to produce reliable statistics on sources of health care coverage among the U.S. population. The following list contains definitions of terms used by EBRI to define coverage groups and population groups.

Children. Includes all children age 14 or less and children over age 14 who are nonworker dependents. That is, they report no work and are not the family head.

Employer coverage. Includes coverage from own employment (direct coverage) and/or coverage as a dependent of a worker covered by employer-provided health insurance (indirect coverage).

Family head. The family member with the highest 1985 reported earnings. In nonworker families, the family head is the family member with the highest reported personal income.

Family income. Income of all family members from any source. Includes earnings and non-labor income.

Full-year, full-time worker. Worker was employed for at least 35 weeks during the year, worked 35 hours or more in a typical week, and reported no unemployment.

Full-year, part-time worker. Worker was employed for at least 35 weeks during the year, worked less than 35 hours in a typical week, and reported no unemployment.

Nonelderly population. All people less than age 65, except people employed in the military and in agriculture, and members of their families.

Nonworker. People age 15 or over who neither worked nor sought work during 1985.

Part-year worker. Worker worked or sought work during the year, but for less than 35 weeks.

Personal earnings. Wages and salaries and self-employment income reported by individual worker.

Poverty level. Poverty levels are determined on a case by case basis according to particular family characteristics such as family size and number of children in family.

Private coverage. Includes employer coverage and individual or other private group coverage.

Public coverage. Coverage from Medicaid, Medicare, or the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS).

Sometime unemployed worker. Worker was employed or sought employment 35 or more weeks during the year and reported at least one week of unemployment. Excludes workers who worked or sought work for less than 35 weeks.

Statement

by

Haynes Rice
Hospital Administrator

HOWARD UNIVERSITY HOSPITAL
2041 GEORGIA AVENUE, N.W.
WASHINGTON, D.C. 20060

INTRODUCTION

THANK YOU FOR THE OPPORTUNITY TO SHARE WITH THE CONGRESS MY DEEP CONCERN OVER THE PROBLEM OF INDIGENT CARE. I WANT TO BEGIN BY APPLAUDING THE MEMBERS OF YOUR SUBCOMMITTEE FOR TACKLING THIS DIFFICULT ISSUE. I PERCEIVE IT TO BE THE FASTEST GROWING PROBLEM IN THE HEALTH CARE INDUSTRY TODAY AND THE ONE MOST LIKELY TO JEOPARDIZE THE ABILITY OF POOR AMERICANS TO RECEIVE QUALITY CARE.

I HAVE CHOSEN TO FOCUS MY REMARKS ON INDIGENT CARE AS IT RELATES TO THE SITUATION IN THE DISTRICT OF COLUMBIA. MY REASONS FOR DOING SO ARE QUITE SIMPLE:

1. THE CITIZENS OF THE DISTRICT SUFFER DISPROPORTIONATELY FROM MOST CHRONIC ILLNESSES AND, HENCE, ARE MOST IN NEED OF QUALTY CARE; AND,

2. DISTRICT HOSPITAL'S UNCOMPENSATED CARE BURDEN IS 20% HIGHER THAN THE HIGHEST STATE IN THE NATION AND IS EXPECTED TO RISE WITH THE ONSLAUGHT OF NEW AIDS PATIENTS IN THE NEXT FEW YEARS.

IN ADDITION, I BELIEVE THAT MY ADDING TO THAT DISCUSSION SOME OF THE EXPERIENCES WE AT HOWARD HAVE ENCOUNTERED AS THE SECOND LARGEST PROVIDER OF MEDICAL CARE TO THE UNINSURED IN THE DISTRICT WILL BE VERY EFFECTIVE IN CONVINCING LEGISLATORS THAT EMERGENCY MEASURES MUST BE PUT IN PLACE IMMEDIATELY TO COMBAT THIS PROBLEM.

INDIGENT CARE AT HOWARD UNIVERSITY HOSPITAL

HOWARD UNIVERSITY HOSPITAL IS A 500 BED ACUTE CARE FACILITY LOCATED IN THE D.C. INNER CITY. AS THE FORMER FREEDMEN 'S HOSPITAL, IT HAS A VERY UNIQUE HISTORY, IN THAT IT WAS ESTABLISHED BY THE FEDERAL GOVERNMENT IN 1863 TO PROVIDE MEDICAL CARE FOR FORMER SLAVES. IN ADDITION, IT HAS BECOME THE LARGEST MINORITY TEACHING HOSPITAL IN THE NATION HAVING GRADUATED MANY OF THE MINORITY HEALTH PROFESSIONALS CURRENTLY PRACTICING AROUND THE WORLD.

WE TAKE THESE RESPONSIBILITIES VERY SERIOUSLY AND ARE FORTUNATE TO HAVE FEDERAL FUNDS TO HELP US IN THESE ENDEAVORS. IT IS VERY UNLIKELY THAT WE WOULD BE ABLE TO OFFER THE TYPES OF SERVICES WE CURRENTLY RENDER WITHOUT FEDERAL FUNDING BECAUSE IN 1985 WE PROVIDED NEARLY $37,000,000 WORTH OF CARE TO THE INDIGENT, SECOND ONLY TO THE CITY'S PUBLIC HOSPITAL, D.C. GENERAL, WHICH PROVIDED $39,360,000 WORTH OF CARE. (SEE ATTACHMENT 1) DISCUSSIONS WITH HEALTH CARE PROVIDERS FROM OTHER PARTS OF THE COUNTRY WOULD ATTEST TO THE FACT THAT LOSING THAT MUCH INCOME IN A GIVEN YEAR WOULD CAUSE MOST FACILITIES TO CLOSE. MORE IMPORTANTLY, THEY WOULD QUESTION WHY SUCH EXPENDITURES ARE NECESSARY.

DISEASES LIKE CANCER, INFANT MORTALITY, DIABETES, HEART DISEASE AND STROKE, WHICH ARE VERY EXPENSIVE TO TREAT, ARE MORE PREVALENT AMONG BLACKS IN THE DISTRICT THAN IN ANY OTHER AMERICAN CITY. KIDNEY DISEASE, WHICH CAN BE TREATED WITH DIALYSIS, COSTS THE NATION BILLIONS OF DOLLARS ANNUALLY UNDER THE MEDICARE PROGRAM AND THE DISTRICT LEADS THE NATION IN THIS DEBILITATING DISEASE. IT STANDS TO REASON THAT OUR LEADERS CANNOT IGNORE THE CITY'S HEALTH PROBLEMS BECAUSE THE TOTAL NATION IS BEING ADVERSELY AFFECTED.

FURTHERMORE, RESEARCH REVEALS THAT MINORITY PERSONS ARE LEAST LIKELY TO SEEK MEDICAL CARE AT THE ONSET OF AN ILLNESS. PERSONS WITHOUT INSURANCE (AND MANY IN THAT CATEGORY ARE ALSO BLACK) ALSO WAIT UNTIL THE DISEASES ARE IN THEIR FINAL STAGES BEFORE CONSULTING A DOCTOR. THEY THEN USE EMERGENCY ROOM AND CLINIC SERVICES. THESE PERSONS NEED SOME TYPE OF ASSURANCE THAT CARE WILL BE PROVIDED TO THEM REGARDLESS OF THEIR ABILITY OR INABILITY TO PAY.

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THE TYPES OF SERVICES PROVIDED BY HOWARD HOSPITAL HAVE BEEN UNIQUELY TAILORED TO MATCH THE PATIENT AND STUDENT POPULATIONS PREVIOUSLY DESCRIBED. WE HAVE TWO NIH DESIGNATED CENTERS -- A COMPREHENSIVE CANCER CENTER AND A CENTER FOR SICKLE CELL DISEASE. OUR CANCER CENTER IS CURRENTLY CONDUCTING RESEARCH TO DETERMINE WHY PERSONS FROM CERTAIN SECTIONS OF THE CITY ARE AT HIGHER RISK OF CONTRACTING CANCER. OUR SICKLE CELL CENTER HAS CONTRACTED WITH THE DC GOVERMENT TO PROVIDE TESTING FOR SICKLE CELL AND OTHER METABOLIC CHILDHOOD DISEASES. WE HAVE THE NATION'S ONLY MINORITY RUN KIDNEY TRANSPLANT CENTER WHICH OFFERS TRANSPLANTS TO AREA RESIDENTS, REGARDLESS OF THEIR ABILITY TO PAY, AS AN ALTERNATIVE TO DIALYSIS. WE HAVE A COMPREHENSIVE MATERNITY AND PEDIATRIC CARE PROGRAM WHICH SPECIALIZES IN LOW BIRTH RATE BABIES, MANY OF WHICH ARE BORN TO I.V. DRUG ABUSERS AND AIDS VICTIMS. THESE CHILDREN, WHO ARE OFTEN BORN WITH DEVELOPMENTAL PROBLEMS ARE TREATED AT OUR CHILD DEVELOPMENT CENTER THROUGH THE ADOLESCENT YEARS. THESE PATIENTS ACCOUNT FOR MUCH OF THE UNCOMPENSATED CARE DISPENSED BY OUR STAFF.

WE HAVE ESTABLISHED THE FIRST NEUROVASCULAR SCREENING LABORATORY IN THE D.C. AREA, A VITILIGO CENTER, AND A PIONEER INTRAOPERATIVE RADIOTHERAPY PROGRAM WHICH IS BEING DUPLICATED ALL OVER THE COUNTRY. I LIST OUR SERVICES WITH PRIDE BECAUSE THEY ARE OFTEN UNAVAILABLE TO POOR PEOPLE IN OTHER PARTS OF THE WORLD.

I IMPLORE YOU AND YOUR COLLEAGES TO THINK OF THE GREAT CONSEQUENCES TO THE CITIZENS OF THE DISTRICT AND THE NATION (SINCE WE ARE A TEACHING HOSPITAL) IF WE ARE FORCED TO CLOSE OUR DOORS.

REPERCUSSIONS

WHILE WE HAVE SOUGHT TO PROVIDE CARE TO ALL PERSONS NEEDING IT, WE HAVE BEEN ADVERSELY AFFECTED BY THAT POLICY.

1. THE PATIENT BAD DEBT RATIO IS EXTREMELY HIGH. WE HAVE BEEN UNABLE TO COLLECT MORE THAN 5% OF THE DELINQUENT ACCOUNTS.

2. PLANNED EXPANSION OF EQUIPMENT AND FACILITIES WE DEEM NECESSARY TO PROVIDE BETTER CARE LIKE OUR AMBULATORY CARE SERVICES HAVE BEEN DELAYED.

3. SEED MONIES FOR RESEARCH AND NEW PROJECTS LIKE A NEW LIVER TRANSPLANT PROGRAM HAVE BEEN DELAYED.

4. STAFF REPLACEMENT AND PROMOTIONS HAVE BEEN DELAYED AND MANY POSITIONS HAVE BEEN ELIMINATED.

RECOMMENDATIONS

AS YOU ARE AWARE, THE CATEGORY OF PERSONS MOST LIKELY TO FIT INTO THE BAD DEBT CATEGORY ARE THE 18 - 24 YEAR OLDS; WHO ARE USUALLY UNEMPLOYED OR UNDEREMPLOYED. LEGISLATION TO ADDRESS THE INDIGENT CARE PROBLEM MUST TAKE THIS FACT INTO CONSIDERATION BECAUSE HIGH RISK PERSONS SUCH AS TEEN AGE MOTHERS AND DRUG ABUSERS ARE INCLUDED IN THIS CATEGORY. AIDS VICTIMS, WHO ARE CURRENTLY TREATED AS INPATIENTS BECAUSE SUFFICIENT HOUSING IS UNAVAILABLE, ARE ANOTHER LARGE EXPENSE. WASHINGTON, D.C.'S MEDICARE PROGRAM PROVIDES CARE FOR MANY OF THE CITY'S AIDS POPULATION. MEDICAL CENTERS IN OTHER STATES MAY NOT BE AS FORTUNATE AND THEIR EXPENSES MUST BE FINANCED BY OTHER SOURCES.

LEGISLATION NEEDS TO ALSO TAKE INTO CONSIDERATION THE FACT THAT STATE AND LOCAL GOVERNMENTS DO NOT HAVE RESOURCES TO ADDRESS THIS PROBLEM. IT DOES NOT BECOME A PRIORITY FOR THEM UNTIL A MAJOR HOSPITAL IS FORCED TO CLOSE.

I WOULD, THEREFORE, MAKE THREE MAJOR RECOMMENDATIONS;

1) NATIONAL COVERAGE SHOULD BE PROVIDED FOR PERSONS WHO DO NOT QUALIFY FOR MEDICAID.

2) BUSINESSES SHOULD BE REQUIRED TO OFFER INSURANCE TO ALL EMPLOYEES.

3) THE INSURANCE INDUSTRY SHOULD BE ENCOURAGED TO LOWER RATES FOR SMALL BUSINESSES AND FIRMS, ELIMINATING THE MAJOR DISINCENTIVE TO MEDICAL CARE COVERAGE.

ATTACHMENT I

The Cutting Edge

News and Notes About Health

District Hospitals Provide Most Free Care

Uninsured and medically needy people in the District received an estimated $136.3 million in uncompensated care from local hospitals in 1985.

This amount is more than twice the average amount of free care given by hospitals in the Maryland and Virginia suburbs in that year and twice the national average, according to a study by the District of Columbia Hospital Association.

"Although this is an enormous amount of free care, leaders of District hospitals remain concerned that some health care needs of the city's indigent population are not being met," the hospital association's president, Stephen H. Lipson, said late last year when it released its "Study of Hospital Care for the Medically Indigent."

About two thirds of the uncompensated care rendered by District hospitals was charity care; the other third was provided to patients who became bad debts to the hospital when they failed to pay their bills.

City hospitals' uncompensated care charges, as a percent of their total charges, ranked second only to Houston hospitals in 1983 among the nation's 20 largest cities.

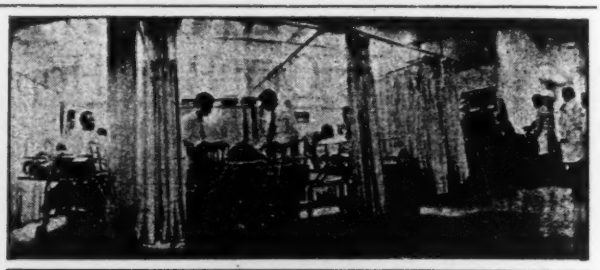
Across the country, dozens of state-level initiatives have been developed to address the uncompensated care issue. These indigent care proposals fall into four broad categories:

- expanding state Medicaid programs;
- developing programs that direct uninsured patients to specific providers of care;
- developing programs that direct payments to hospitals to cover the cost of uncompensated care; and
- creating new programs that provide insurance to needy people.

Last year, the District of Columbia Hospital Association's board of directors approved a list of 18 strategies that it said should be examined to address the indigent care issue. Virtually all of the strategies fell into one of the four categories being pursued by state governments.

"The board directed the association's Task Force for Care of the Medically Indigent to analyze and develop cost estimates for these strategies," said Joan H. Lewis, the association's vice president for communications. "There are no silver bullets for solving this problem, but we believe that a concentrated effort by the task force members will identify the most promising avenues of pursuit."

— John E. Iglehart



UNPAID BILLS

Amount of Charity Care and Bad Debts at District Hospitals

HOSPITAL	1983 AMOUNT (thousands)	1984 AMOUNT (thousands)	CHANGE	1985 AMOUNT (thousands)	CHANGE
Capitol Hill	$2,045	$2,234	9.2%	$2,374	6.3%
Children's	$10,556	$11,226	6.3%	$11,479	2.3%
Columbia Hospital for Women	$1,854	$1,922	3.7%	$2,479	29.0%
District of Columbia General	$38,546	$41,821	8.5%	$39,361	-5%
George Washington University	$5,182	$6,892	33.0%	$8,658	25.6%
Georgetown University	$4,925	$5,040	2.3%	$5,158	2.3%
Greater Southeast Community	$5,568	$7,594	36.4%	$7,711	1.5%
Hadley Memorial	$1,813	$2,169	19.6%	$2,340	7.9%
Hospital for Sick Children	$9	$21	133.3%	$17	-19.0%
Howard University	$22,678	$42,377	86.9%	$37,202	-12.2%
Providence	$4,534	$3,170	-30.1%	$3,780	-19.2%
Sibley Memorial	$655	$693	5.8%	$815	17.6%
Washington Hospital Center	$8,841	$8,984	1.6%	$13,715	52.7%
TOTAL	$107,813	$135,228	25.4%	$136,254	0.8%

Source: DCHA Membership Survey, 1985

THE WASHINGTON POST
HEALTH SECTION
JANUARY 1987

JONES COUNTY
COMMUNITY HOSPITAL

TERRY G. WHITTINGTON
ADMINISTRATOR

March 16, 1987

Joseph K. Dowley, Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Dowley:

I am the Vice-President of the Board of Trustees at a community hospital that has just had to lay off 33 workers. I understand that the Health Subcommittee of the Committee on Ways and Means is looking into the uncompensated care problem, and I have some things I would like to put in the record.

As an independent businessman, I understand the relationship between the amount of work a business has to do and the number of workers needed. It's a fact in the business world that you can't have too much labor for too little work. But if there is a lot of work to be done, the business is going to charge enough for its services to be able to hire enough workers to do it. That is a variation off the old law of supply and demand. But the principal is breaking down in the hospitals today because of the problem of uncompensated care.

At our hospital, we basically cannot collect a third of our charges. This is not the same kind of "bad debt" where a business has made a mistake and issued credit to customers who were poor risks. Jones County Community Hospital cannot get its money because of governmental policy.

On the one hand, the Medicare and Medicaid programs do not repay us adequately for taking care of Medicare and Medicaid patients, and, on the other hand, the government does not help us at all with the burden of caring for people who have no money or insurance of any kind.

We do not turn away any emergency that comes to our Emergency Room. We have that policy because we are required to by Medicare and because it is the decent thing to do. An

PHONE (601) 649-4000 • P. O. BOX 607 • LAUREL, MISSISSIPPI 39440

indigent person can be injured in a car wreck, be admitted to our hospital, receive thousands of dollars of care, and yet have no means to pay. Who is going to pay his bill? Are we going to transfer the cost to the paying patients? Only 3 out of 10 patients we treat have private insurance. There is no way that they can pay the bills of the other 7.

The point I want to make is this. If the government does not find some way to solve this problem, hospitals like ours will be a thing of the past. Oh, we may not have to shut down. But we'll have to cut back so much on services and personnel that it will not be the same kind of hospital that it is now. It'll be a warehouse for the sick and dying, not a place you go to get well.

I know that members of the Health Subcommittee deal everyday with matters of earthshaking importance. But I don't believe that any issue they'll ever deal with is more important to the future of American health care than is the problem of uncompensated care. I earnestly hope that they will find a solution to it.

Sincerely,

Robert Burroughs
Vice President
Jones County Community Hospital

/jh

JONES COUNTY
COMMUNITY HOSPITAL
TERRY G. WHITTINGTON
ADMINISTRATOR

RECEIVED
MAR 16 1987
WAYS AND MEANS

March 10, 1987

Joseph K. Dowley, Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Dowley:

I would like to state for the records of the Health Subcommittee of the Committee of Ways and Means that the burden of uncompensated care is falling unfairly on hospitals like Jones County Comunity Hospital in Laurel, Mississippi.

I am a Trustee of this hospital, and each month I review the institution's financial position. This year we will provide more than $10,000,000 of uncompensated care. Our entire budget is roughly $35,000,000, so we are talking in terms of a third of the hospital's income.

It seems to me that there are several important questions here:

1. Why is our uncompensated care load so high?
2. Where will the money come from to allow us to serve the health needs of our area?
3. What is going to happen to our hospital in the future?

I can answer the first question. Our uncompensated care load is high because of the policies of our government. We do not receive sufficient payment for treating Medicare and Medicaid patients, and the government does not accept any responsibility for the treatment of the indigent who receive care at our facility.

The second question seems to have no ultimate answer. We on the Board struggle each month with this matter, and to deal with it recently, we approved the layoff of 33 people. Traditionally, hospitals have shifted the cost of uncompensated care to the "private pay" patient. Less than 30 percent of our patients are private pay. They cannot absorb the debts of everybody else.

The third question is one that I don't even want to think about--because I see only two solutions. One is a closed hospital. The other is a hospital where the quality of care is so poor that I would not want to be associated with it in any way.

I hope that the Subcommittee will address these questions as they apply not only to our hospital but to all hospitals, for, if they do not--if the questions are left to answer themselves, the result will be a failing grade for the American health-care system.

Sincerely,

Edith East

Edith East
Secretary
Board of Trustees
Jones County Community Hospital

JONES COUNTY
COMMUNITY HOSPITAL
TERRY G. WHITTINGTON
ADMINISTRATOR

COMMITTEE ON
WAYS AND MEANS
MAR 16 1987

March 10, 1987

Joseph K. Dowley, Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Dowley:

Nothing of a professional nature is more important to a physician than the quality of health care in a hospital into which he admits his patients. Since I also serve on the Board of Trustees on the hospital where I admit mine, I am doubly conscious of quality of care, and at this point I am worried.

Jones County Community Hospital in Laurel, Mississippi, is an outstanding medium-sized hospital. The quality of care available here compares most favorable with that available anywhere in a hospital of like size and medical staff composition. It has a physician on duty in its Emergency Room 24 hours a day. It has a 6-bed Intensive Care Unit and a 6-Bed Cardiac Care Unit, with cross-trained nurses. It also has a 20-bed Intermediate Care or "Stepdown" Unit with telemetry cardiac monitors. We have an excellent surgical suite and a highly sophisticated Outpatient Center, equipped with both fiber optics and laser capabilities. We have a complete Obstetrics Unit, a CT scanner, and an excellent Medical Laboratory. In short, we as physicians have the equipment and the support personnel to practice top-quality medicine. But will the hospital still be state of the art in 10 years? I am afraid that it will not.

This year Jones County Community Hospital will render $10,000,000's worth of uncompensated care. Already, we on the Board are having to tool the hospital down in order to be able to carry such a burden. We have curtailed construction. We have cut employee benefits. We have laid off non-patient care employees. If we are forced to make further cuts in the coming year, the only places left to cut will be in areas that affect the quality of care. Do we do away with the Intensive Care Unit? Do we cease to provide obstetrical services? How many nurses can we lay off before the quality of care becomes so poor as to be a legal liability? These are questions that I do not want to face as a physician, but that I may have to face as a Board member.

I would like to go on the record as urging the members of the Health Subcommittee of the Committee on Ways and Means to seek diligently for a solution to the problem of uncompensated care. For if one is not found, the quality of care at Jones County Community Hospital and many other American hospitals will deteriorate to such an extent as to cause grave ethical problems for physicians.

Sincerely,

Charles Hollingshead, M.D.
Trustee
Jones County Community Hospital

JONES COUNTY
COMMUNITY HOSPITAL
TERRY G. WHITTINGTON
ADMINISTRATOR

March 10, 1987

RECEIVED
WAYS AND MEANS

Joseph K. Dowley, Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Dowley:

Congressman G.V. "Sonny" Montgomery notified our hospital that the Honorable Fortney H. Stark, Chairman of the Subcommittee on Health of the Committee on Ways and Means, has called for a hearing on the problem that hospitals are having with uncompensated care and has invited interested parties to make their views a part of the record by providing you with a written statement. As President of the Board of Trustees of Jones County Community Hospital in Laurel, Mississippi and as a practicing physician, I am very familiar with the problem, and am happy for the opportunity to share my perspective with the Committee.

Our cash flow projections show that our hospital Will furnish some $10,000,000 of uncompensated care this year. This figure has three basic components:

1. An insufficient Medicare reimbursement.
2. Our losses incurred treating Medicaid patients.
3. The costs of caring for the indigent.

Because we are faced with this staggering amount of bad debt, we recently had to reduce benefits and layoff five percent of our work force. Taking these steps will allow us to maintain quality of care and keep our doors open if conditions remain the same. However, if the uncompensated care problem worsens, we will ultimately have to reduce the quality of care and, perhaps, close the institution.

Jones County Community Hospital serves a four county area. The people of our service area are poor. The unemployment is twice the national average. Sixty-five percent of our patients are on Medicare, and five percent have Medicaid. There is obviously no way that every increasing amounts of uncompensated care can be shifted to the 30 percent of our patients who can pay. If a solution to the problem is not found at the Federal level, I do not see how Jones County Community Hospital can continue over the long run to meet the health care needs of the 120,000 people we now serve.

Sincerely,

Eric Lindstrom, M.D.
President, Board of Trustees
Jones County Community Hospital

JONES COUNTY
COMMUNITY HOSPITAL

TERRY G. WHITTINGTON
ADMINISTRATOR

March 10, 1987

MAR 1 5 1987

Joseph K. Dowley, Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Dowley:

I am an American, a Jones County Mississippian, a Black woman, and a retired Licensed Practical Nurse. I also am a Trustee of Jones County Community Hospital in Laurel, Mississippi. All these things add up to color how I view what is happening around me today, and I do not like what I am seeing.

My hospital--a place where I worked for 17 years before my retirement-- is being crushed under the weight of providing uncompensated care. I have been forced to vote to cut the health benefits of my friends and former co-workers, because the hospital had to cut its expenses or close its doors. We have even had to lay off employees for the first time in our history. And, sir, these were not just numbers on a personnel list to me. They were people I knew like members of my own family.

The economic conditions of our town and county are terrible. Our economy was built on the oil and timber industries, and those industries are in depression. Everywhere people are out of work with no hope of finding jobs. Yet, those people get sick and they have to be taken care of. As a nurse, I can not tolerate the idea of turning sick folks away without care. But I know that if some way is not found to reimburse us for the cost of treating them, our hospital will not long endure.

I have been told that the gentlemen of the Health Subcommittee of the Committee on Ways and Means are going to investigate the problem of uncompensated care. My message to them is that they must find a way to solve the problem. Jones County Community Hospital will provide $10,000,000 worth of cre this year for which we will not be paid. It does not take a fortune teller to foresee that we cannot do that for many more years. A retired L.P.N. can look that far into the future.

Yours truly,

Luella Newsome, LPN

Luella Newsome, L.P.N.
Treasurer
Board of Trustees
Jones County Community Hospital

JONES COUNTY
COMMUNITY HOSPITAL
TERRY G. WHITTINGTON
ADMINISTRATOR

COMMITTEE ON
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WAYS AND MEANS

March 10, 1987

Joseph K. Dowley, Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Dowley:

I have a few thoughts I would like to pass along to the members of the Health Subcommittee being chaired by Mr. Stark. I am going to limit them mostly to something that I have had a little experience with, which is politics.

I spent most of my working life in Jones County, Mississippi politics, serving the people as Chairman of the Board of Supervisors for a number of years. Now in my retirement, the people have asked me to serve as a Trustee of Jones County Community Hospital, which I am pleased to do. Our hospital, which I helped plan and build during my years as Supervisor, is in grave trouble. We are having to take care of a lot of people who just don't have the money to pay their bills. This year we are going to furnish $10,000,000 worth of uncompensated care. The reason that figure is so large is because of the Medicare program and because we treat a lot of indigents through our emergency room. If we keep giving out that much free care every year, we obviously are going to go broke one of these days. That would not only be bad medically and bad from a human kindness point of view, it would be bad politics.

This hospital belongs to the people of Jones County. They built it with their own money -- except for a little Hill-Burton money they got from Congress. And they run it completely with their own money from the fees the hospital gets for taking care of folks. It this hospital has to shut down because the Federal government can't find a solution to the problem of uncompensated care, there are going to be some mad voters in Jones County. Now, of course, that is not going to affect the national scene too much. But if you multiply those angry voters by the thousands of hospitals similar to ours that are in trouble because of uncompensated care, you can see what a political issue that it could be to be.

So, I'd just like to point out to the honorable gentlemen on the Health Subcommittee, as they begin their work, that they give their best effort to finding a solution to the problem of uncompensated care, not only because it is the right thing to do, but because it makes just plan good old political horse sense as well.

Thank you.

Sincerely,

James W. Rasberry
Trustee
Jones County Community Hospital

JONES COUNTY
COMMUNITY HOSPITAL
TERRY G. WHITTINGTON
ADMINISTRATOR

March 10, 1987

COMMITTEE ON
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MAR 16 1987
WAYS AND MEANS

Joseph K. Dowley, Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Dowley:

I am a Trustee of Jones County Community Hospital of Laurel, Mississippi, and I would like to inform the Health Subcommittee of the Committee on Ways and Means that the current health care policies of the federal government are causing some severe problems for our institution:

1. They are denying us adequate payment for treating our Medicare and Medicaid patients.

2. They are forcing us to employ personnel that we would not otherwise need in order to meet the paperwork demands for Peer Review Organizations and other agencies.

3. They are requiring us -- as does human compassion -- to treat all emergencies presented to the hospital; however, the policies do not make provision to help bear the cost of caring for the large segment of emergency patients who are indigent.

Because of these three problems, our hospital will furnish more than $10,000,000's worth of care for which it will not be paid this year. Obviously, we are being forced into a precarious financial position. We will not remain financially sound if this situation continues year after year.

I am sure there are those who would say that the answer for us is to cut our expenses. Mr. Dowley, we have already reduced our employees' benefits significantly and laid off 33 workers. If we are forced to reduce personnel further or to curtail services, the quality of care rendered in this hospital will suffer dramatically.

The area that we serve is already disadvantaged. Its economy has been crippled by depression in the oil industry. Unemployment in the area doubles the national average. Furthermore, the population is aging. Sixty-five percent of our patients are Medicare recipients. Cutting the quality of health care available to these people would be like lashing the back of a starving man.

I think that it is extremely important that the Subcommittee come to grips with the direction in which federal governmental regulations are carrying hospitals. I believe that if that direction is not changed, high quality health care in America will become a thing of the past.

Sincerely,

Frank Therrell
Jones County Community Hospital
Board of Trustees

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS 1400 Twenty-First Street, N.W., Suite 10, Washington, D.C. 20036 (202) 66[illegible]

Denver General Hospital
Boston City Hospital
District of Columbia General Hospital
Harris County Hospital District (Houston)
University of Medicine and Dentistry of New Jersey University Hospital
Grady Memorial Hospital (Atlanta)
Cleveland Metropolitan General Hospital
Santa Clara Valley Medical Center (San Jose)
The Los Angeles County Hospitals
Portland Memorial Hospital (Dallas)
Truman Medical Center (Kansas City)
San Francisco General Hospital
Bellevue Hospital Center
Bronx Municipal Hospital
Cook County Hospital
Contra Costa County Health Services Department
Brackenridge Hospital (Austin)
Wishard Memorial Hospital (Indianapolis)
Chope Community Hospital (San Mateo)
Worcester City Hospital
Alameda County Health Care Services Agency (Oakland)
Westchester County Medical Center
Milwaukee County Medical Complex
Nassau County Medical Center
Regional Medical Center at Memphis
Pacific Medical Center (Seattle)
University of New Mexico Hospital
Harborview Medical Center University of Washington
Fresno County Valley Medical Center
General Hospital Ventura County
R.E. Thomason General Hospital (El Paso)
Kern Medical Center (Bakersfield)
University of Cincinnati Hospital
University of Texas Medical Branch
Queens Hospital Center
Hurley Medical Center (Flint)
San Bernardino County Medical Center
San Joaquin General Hospital (Stockton)
Riverside General Hospital, University Medical Center
Oregon Health Sciences University Hospital
Spartanburg General Hospital (Spartanburg, SC)
Harlem Hospital Center
Charity Hospital of Louisiana
Maricopa Medical Center (Phoenix)
St. Louis County Hospital
Memorial Medical Center (Savannah, GA)
Amarillo Hospital District
Jackson Memorial Hospital (Miami)
Pontiac General Hospital (Pontiac, MI)
Clinton Memorial Hospital (Wilmington, OH)
Earl K. Long Memorial Hospital (Baton Rouge)

FOR THE RECORD

STATEMENT OF LARRY S. GAGE
President
National Association of Public Hospitals
Washington, D. C.

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
March 12, 1987

Mr. Chairman, members of the Subcommittee, I am Larry S. Gage, President and General Counsel of the National Association of Public Hospitals. NAPH consists of 75 public hospitals and hospital systems that serve as major referral centers and hospitals of last resort for the poor in most of our Nation's largest metropolitan areas.

I welcome the opportunity to submit this testimony to the Subcommittee this morning, and to provide you with some general background information and recommendations, as a supplement to testimony being presented by NAPH members Jim Mongan, of Kansas City, Missouri and Joel Allison, of Amarillo, Texas. We believe this additional information may be helpful to you as you consider possible ways to increase the federal role in funding health services for the indigent and the uninsured.

It has not been fashionable since the late 1970s to talk of significantly expanding our nation's health insurance coverage. This has been true for budgetary as well as for political reasons.

In the last two fiscal years, however, we are encouraged that health care for the poor has begun to emerge again as a Congressional budget priority, at least in the House of Representatives. The results have been several modest initiatives, whose primary impact has been to shield low income patients, and the institutions that serve them, from the full burden of other budget reductions. But while this renewed budget process emphasis has been important, these initiatives can in no way be considered a significant "expansion" of nationwide health insurance coverage or federal indigent care funding. Rather, from the vantage point of NAPH member hospitals, we are continuing to slip backwards in this vital area, at an increasingly alarming pace.

For despite these recent improvements in a few selected areas, the health coverage gaps have continued to widen for our nation's elderly, poor and disabled citizens. Most analysts now agree that Medicare covers well under half of the health care costs of the elderly. Medicaid, which in 1976 covered 65% of the population with incomes below 125% of the federal poverty line, dropped precipitously to cover just 54% of the poverty population in 1980, and to less than 40% as of 1984.

The burden has therefore continued to increase for NAPH member hospitals and other hospitals that provide a disproportionate share of health services to uninsured or underinsured individuals.

For these reasons, NAPH strongly supports your Subcommittee's expressed goal of developing a new program of targeted support for low income patients and the hospitals that serve them. We offer you whatever resources we have

available to assist you in the design and development of such a program, and the achievement of its enactment.

In this regard, I would like to accomplish three things in the remainder of the prepared testimony I am submitting this morning. First, I would like to provide you with updated information on the situation of NAPH member hospitals and other important safety net hospitals in America today, with particular attention to recent trends affecting the role of such institutions in serving uninsured and low income patients. Second, I would like to elaborate on our offer of strong support, and provide you with several suggestions regarding a possible new federal program to help finance indigent care. Third, I would also like to comment briefly on the possible impact on NAPH members of several other important issues or proposals currently pending before the Congress.

I. The Current Situation of "Disproportionate Share" Hospitals

Your Subcommittee has paid welcome attention in recent years to the valuable public hospital network that serves as the foundation of America's health system. This network consists of a surprisingly small handful of major metropolitan area hospitals whose open doors guarantee access to essential health care services for poor and non-poor patients alike.

While these "open door" hospitals include a small number of non-profit and for-profit community hospitals, most of them are governmentally-supported institutions that include city and county hospitals, state universities, hospital districts and authorities, and quasi-governmental hospitals. The American Hospital Association (AHA) Commission on Public General Hospitals

identified as the core of this system just 90 major urban public hospitals, and 45 state university teaching hospitals, in its 1978 report.

While these disproportionate share "safety net" hospitals operate under a variety of legal structures, they nevertheless share a common mission, and an important range of common characteristics, that set them apart from other community hospitals. Such hospitals usually provide a significantly higher volume of inpatient and outpatient services than their private sector counterparts; have seen recent increases in admissions, OPD/ER visits, and (unlike other hospitals) occupancy rates; provide many unprofitable tertiary and specialized services; and are major educators of our nation's physicians and nurses. Not the least of these unique characteristics is that they are funded to a greater degree than their private sector counterparts by federal, state and local governmental payers and appropriations. Finally, they continue to bear an enormous, and increasing, share of the nation's burden for care to the uninsured and underinsured in comparison with all other segments of the hospital industry. In the remainder of this section, I will draw upon recent statistics relating to NAPH members and several other newer data sources, to illustrate these common characteristics of our nation's great public hospitals.

A. Volume of Services

Although small in number, NAPH member hospitals are substantial in the sheer volume of care they provide. Just 43 NAPH members experienced over one million inpatient admissions and over 13 million outpatient/emergency room visits during 1985. Member hospitals averaged over 22,000 admissions and

310,000 outpatient and emergency room visits each for that year. NAPH member hospitals and hospital systems in 12 major metropolitan areas provided 25% or more of the total amount of outpatient department and emergency care in those cities. Hospitals such as Grady Memorial Hospital in Atlanta (75%) or R.E. Thomason in El Paso (48%) provide such care well out of proportion to the number of beds they represent in their communities.

According to NAPH, AHA, and Urban Institute data, the predominant categories of patients served by these institutions are Medicaid and the indigent. For example, during 1984, NAPH members reported, on average, 31% of their inpatient days (49,000) and 51% of the their outpatient visits (130,000) as lacking either governmental or private insurance. Another 25% of their inpatient days and approximately the same proportion of their outpatient visits were related to Medicaid patients.

B. Admission and Visit Trends

Important changes have taken place in service utilization among NAPH members between 1983 and 1985. While most U.S. community hospitals have seen a continuing decrease in admissions in the 1980s, NAPH member admissions have increased. Between 1983 and 1985 a 9.3% increase occurred. Outpatient visits increased 25% during that period, while emergency room visits remained the same.

C. Occupancy Rates

The average occupancy rate for NAPH member public hospitals remains far above the overall average for U.S. community hospitals. According to the AHA, average occupancy rates for the nation's community hospitals continued to decline, from 75% in 1975 to 69% in 1984 to 64.8% in 1985. NAPH member occupancy rates, on the other hand, averaged 80% in 1985, which is consistent with 1984 member rates. When compared specifically with hospitals in their communities, 75% of NAPH members had occupancy rates higher than the cities' other institutions.

D. Emergency Care

In large cities, emergency rooms are often the primary source of admissions to public hospitals. For these institutions including NAPH members (where almost 50% of their inpatient admissions occur through their emergency rooms), the severity of the presenting conditions for these patients can have a profound effect on service intensity and on hospital resource use.

A recently completed study investigated emergency room care costs in the context of the Medicare change from cost-based to prospective payment. (Munoz, et al, 1986). The research directly addressed one fundamental question in particular: are Medicare ER admissions in urban public hospitals more expensive than Medicare non ER admissions? Identifying surgical admissions to the eleven acute care hospitals of the New York City Health and Hospitals Corporation (HHC) over an eighteen month period, the study matched DRGs (ER vs. non ER) and reviewed cost per patient data for 26,564 cases.

The public hospital information uncovered a dramatic pattern: 75.8% of all surgical admissions occurred in DRGs where ER admissions were more costly

than non ER admissions, at an average of 125% higher. Of the DRGs where non ER admissions were more costly, the average was 46% higher. Results, in general, were consistent across all HHC institutions.

E. Specialized Services

In addition to general inpatient and outpatient services, public hospitals provide essential specialty care in their communities without regard to the profitability of such services. For example, of six such specialty services identified by the Urban Institute in 1982 — coronary care units, neonatal ICUs (NICU), pediatric ICUs (PICU), burn, organized OPD, and psychiatry — public hospitals were more likely to have any or all of these services. NICUs, PICUs and burn units were 2 1/2 - 3 1/2 times more likely to be found in public hospitals than in private facilities.

NAPH members are responsible for providing a substantial amount of prenatal, perinatal, and postnatal care in major U.S. cities. During 1985 just 40 NAPH members account for 5.5% of all newborns delivered in U.S. community hospitals, averaging over 4,800 per facility. OB/GYN admissions averaged 6,177 per reporting NAPH member hospital. OB/GYN outpatient visits, at almost 30,000 per facility, represent an estimated 13% of all outpatient visits to NAPH member institutions.

NAPH members who offer psychiatric services serve as a significant resource for their communities. Thirty-eight members identified over 44,000 psychiatric admissions during 1985, an average of almost 1,200 per facility and approximately 5% of all member admissions.

F. Sources of Revenue

Support for low income patients through Medicaid and city, county, and state funds continued to represent the major sources of revenue for large city public hospitals. During 1985, these sources contributed, on average, 32% and 28% respectively to the $110 million average total net revenues for NAPH member institutions. Private insurance was the lowest contributor, representing 13% of total net revenues, while Medicare provided 17%.

G. Medical Education

NAPH members continue their commitment as major medical institutions. Forty-two reporting NAPH member hospitals trained 8,800 residents, an average of 211 per hospital and representing 12% of all residents trained in 1985. The average ratio of residents per bed, .37, indicates the depth of their involvement in physician training.

H. Care to the Uninsured and Underinsured

Although the characteristics set out above clearly distinguish safety net hospitals from the rest of our nation's health care providers, it is their provision of care to the medically disenfranchised, and the consequences they suffer in that role, that place these hospitals in particular jeopardy. Their present situation has been keenly affected by a number of factors, including the increasing medically indigent population, decreases in Medicare coverage of health care costs, and the decline in Medicaid coverage.

We have used NAPH, Urban Institute, AHA and other sources of information to document both the magnitude of indigent care provided by urban public "safety net" hospitals, in comparison with private hospitals, as well as the fiscal impact of being such a hospital. Our preliminary findings are that NAPH member hospitals and similar institutions:

1. Provide over four times more charity care. . .

   During 1982, urban public hospitals rendered an average of $32,100 in bad debt and charity care per bed, compared with about $7100 for urban non-profits. While urban public hospitals represent 5% of the beds in the country, they provided over 40% of the charity care nationally in that year.

2. Provide twice as much Medicaid care . . .

   Urban public hospitals provide almost twice as much Medicaid care as their private sector counterparts ($10 million vs. $5.3 million during 1980), and preliminary data indicates they provide a substantially higher proportion of care to Medicare SSI patients as well.

3. Provide substantially more indigent care today than in the past . . .

   Between 1982 and 1984, public hospitals demonstrated a substantial increase in their indigent care commitment; the average NAPH member hospital spent $13 million more in 1984 on care for the medically indigent, an 8.4% increase from 1982. Bad debt/charity care represented 25% of these hospitals' average total charges.

4. Are more likely to operate at a deficit . . .

   Many urban public hospitals operate at a loss, even after local governmental subsidies are taken into account. According to 1982 Urban Institute data almost 50% of the public institutions experienced deficits (19/39) compared with only 22% of the non-profits (56/260) in the nation's largest cities. For the facilities with deficits, the negative

margin was over five times higher for public hospitals and was directly attributable to the substantially higher volume of services to low income patients as measured by bad debt and charity care in the public facilities. For 1984, the proportion of NAPH members incurring deficits has remained exactly the same.

5. Have taken significant cost cutting steps without reducing services . . .

Actions taken by NAPH members to compensate for their financial situation demonstrate a major effort to adjust to financial problems internally without disrupting services. For example, several NAPH members have experienced layoffs, postponed pay increases, or deferred maintenance, while others have attempted to become more competitive through shared services, managed care, or HMO affiliations. Virtually no major public hospitals have adopted Medicaid or charity care limits or cut service hours.

6. Have been forced to turn away privately insured patients . . .

While some NAPH members have sought to raise more private patient care revenues, others have found that their mission of providing care to the medically indigent threatens to erode their small but critical private pay base. For example, San Francisco General Hospital, Houston's Harris County Hospital District, the Regional Medical Center at Memphis and other NAPH member hospitals have recently begun to divert privately insured patients to other hospitals because certain inpatient services are operating at 100% capacity.

I. Comparison With Other Teaching Hospitals

Finally, it must be pointed out that while public and private teaching hospitals together provide much of the uncompensated hospital care in this country, public teaching hospitals carry a significantly disproportionate share of that burden as well. The 1985 Commonwealth Fund Study on Academic

Health Centers reported that although teaching hospitals generally represent less than 6% of U.S. community hospitals in America, they provide almost 50% of the indigent care. However, while the average private teaching hospital's bad debt and charity care was 5% of gross patient revenues in 1982, the public teaching hospital's average bad debt and charity care was over three times that amount (16.7%). While public teaching hospitals provided 11% of all hospital care in 1982 (based on adjusted patient days), they accounted for 31% of all uncompensated hospital care in the nation's 100 largest cities. In fact, if we use 10% of gross patient revenues allocated to bad debt and charity care to indicate a "high volume" provider of indigent care, 53% of all public teaching hospitals would be considered "high volume" providers, but only 8% of private teaching hospitals.

As the differences in the amount of indigent care rendered are self-evident, so too are the consequences for the public teaching hospital. According to Urban Institute information, almost 50% of public teaching institutions in large cities had overall deficits, compared with 17% of the private teaching hospitals. Those public teaching hospitals with deficits incurred an average negative margin of 14.7%, almost 7 times higher than those private teaching hospitals with deficits. Such findings have led the Commonwealth Fund to conclude, "Consistent with their mission, these public teaching hospitals, along with other public hospitals, care for more charity, bad debt and Medicaid patients than any other category of hospital (emphasis added). As a result, they may be more likely to suffer financial stress. . . . The[se] stressed hospitals had fewer opportunities to shift the cost of uncompensated care to other payers . . .."

II. Comments on Proposed New Indigent Care Program

For all of the reasons outlined above, NAPH member hospitals strongly support proposed efforts by your Subcommittee to develop new programs to fund or provide health care for uninsured Americans. In that regard, several key questions come to mind:

- Should such a program be a grant program or an entitlement?
- If a grant program, which providers should be targeted to receive such support? Should it be provided automatically by formula, or through an application process? Should specific services or patient populations be targeted? Should a financial viability and/or distress test be applied? And how can appropriate geographic or demographic distribution of any funds best be achieved — with the assurance that the funds will supplement, not supplant, current state and local initiatives?
- How should the program be funded?

We do not pretend to have the answers to all of these questions, although as I hope I have indicated in my testimony, NAPH member hospitals are unusually well suited to assist you in this effort.

With regard to possible new entitlement programs, as the primary providers of hospital care to the uninsured in America, our hospitals essentially serve as "national health insurance" by default in many cities. As such, we can help you identify those insurance gaps most in need of being filled by new efforts on the entitlement side of the equation. We recognize that substantial improvements in health insurance coverage are likely to be costly budget items, and we do not propose any such initiatives at the present time. However, we strongly support your efforts to make incremental

improvements in areas such as Medicare catastrophic insurance and the ACCESS legislation proposed by Chairman Stark, Senator Kennedy and others. We hope, as some have suggested, that you can go farther in expanding those initiatives, even within current budget constraints. We also welcome your support for efforts we hope will be undertaken by the relevant Committee to expand Medicaid coverage as well.

Realistically, however, due to budget constraints, it is inevitable that major health coverage gaps will remain. For this reason, we believe that some form of direct federal payments or targeted institutional assistance will be necessary for those hospitals that are on the front lines providing this care. We would strongly urge you to give careful consideration to a limited program of direct institutional assistance to public and private disproportionate share providers with the characteristics we have described in our testimony.

Interestingly enough, there has never been a program of direct federal aid to hospitals serving the poor, despite the significant funding devoted to community health centers, mental health centers, drug abuse treatment programs and other kinds of health care providers. Indeed, in 1982, as part of a major emergency anti-recessionary supplemental appropriation, the House of Representatives first considered it desirable to include such targeted hospital grants, and added $55 million for that purpose to the emergency supplemental. However, because there was no explicit statutory authorization for such grants at the time, the House was forced to appropriate the money to the Preventive Health Block Grant, administered by the Centers for Disease Control. Frankly, CDC wanted no part of this new program, and it therefore fell through the cracks in the House-Senate Conference.

In order to remedy this lack of authorization, the House of Representatives the following year included specific authorization for such a program, in the form of Title C of H.R. 3021, the Health Care for the Unemployed Act of 1983. That bill passed the House, but not the Senate. Title C provided for a grant program for public and private hospitals providing disproportionate health services to the unemployed. I have attached a copy of this title and its accompanying report language to my testimony today.

It should be noted that, while the underlying justification for including Title C in the 1983 bill was the unemployment crisis then confronting the nation, many of the issues that you would need to consider in adopting such legislation today were also considered at that point. Such issues included the extent to which the program could be targeted on those hospitals most in need, requirements that such hospitals maintain an open door for all patients, and efforts to guarantee the maintenance of local effort, so that new federal dollars would supplement, not supplant, existing state and local funding. We would be happy to work with the Committee to explore the importance of these concerns, as well as other possible ways to target the resources of such a program most efficiently.

With regard to funding, the simplest and most direct method available to your Subcommittee would be an additional formula-based allocation through the Medicare process to some or all of those hospitals you have already identified as being eligible for a disproportionate share hospital adjustment. In our experience, the Medicare adjustment formula has indeed targeted the right hospitals, and fairly accurately measured the relative amounts of care

provided to the low income patient. If the Committee wishes to target its assistance more narrowly, there is already precedent in the Medicare program for further limiting assistance to those hospitals serving the most significant such role. For example, an exemption from PIP repeal, which was provided last year to some but not all hospitals receiving Medicare disproportionate share adjustments. The funding mechanism in this case would simply be through an allowance in the overall reconciliation process set aside for this purpose.

If other sources of funding are required, obviously Ways and Means is also the right Committee to consider such sources. For example, a limited excise or "life style" tax, tax increase on alcoholic beverages or cigarettes, may be dedicated to funding indigent care. In conclusion, we are confident this Committee can come up with an adequate limited funding source for such a target grant program.

III. Other Concerns of Disproportionate Share Hospitals

In conclusion, I would just like to offer observations about the possible impact on NAPH member hospitals of your current debate in several additional areas. Those include the Medicare capital pass-through, public hospital access to capital, the issue of so-called Medicare "profits," and the continuation of the Medicare disproportionate share hospital adjustment and the exemption of some of the hospitals receiving that adjustment from the repeal of PIP.

First, with regard to capital, as you are aware, our nation's urban public hospitals on average experience the lowest proportional Medicare "pass-through" payments of any segment of the hospital industry — under 4% by most standards, compared with over 7% for the industry as a whole. Many public hospitals would therefore potentially have something to gain from a rapid — indeed, an immediate — phasing of capital payments into overall PPS payments. However, we do not support such a move at the present time. For one thing, as in the rest of the industry, such a move would divide the haves from the have-nots even among public hospitals — harming those safety net hospitals who have recently been able to rebuild for the benefit of those with older physicial plants who may not need capital in the near future.

On the other hand, in a "zero sum" game, protecting those hospitals with past capital expenditures may not leave nearly enough room for those safety net hospitals with major future capital needs. This would be particularly true if this Committee yields to the pressure you have received from some segments of the industry (including some NAPH members) to "grandfather" payments to hospitals that have recently rebuilt their facilities. We would oppose such a system unless it also provided an adequate "outlier" policy to allow for future capital needs for at least "disproportionate share" hospitals. Since this is more or less the system already in place, we therefore urge the Subcommittee to continue that system.

It is important to note that Medicare capital reimbursement alone will not solve the underlying capital problem that will be faced by most of our nation's safety net hospitals in the next several years — that is, gaining access to capital in the first place. In that regard, we have for several

years been attempting to seek enforcement of an amendment adopted by the Congress in 1983 opening up the FHA mortgage insurance program for the first time to public hospitals. The Administration has consistently refused to implement this program in an adequate fashion, and we may require your support for additional legislation this year in that area. In addition, it is likely that we will be asking the Congress to adopt a specific capital access initiative of some kind, also targeted on disproportionate share hospitals, later this year.

In addition to access to capital, there are several other issues that re-emerge for consideration this year which are important to public hospitals. With regard to the issue of "Medicare profits," for example, we note that most analysts have taken care to address the problem of indigent care. For example, Assistant CBO Director Nancy Gordon, in testimony presented to this Committee on February 26, pointed out:

> "Yet another factor to consider is that the overall health care system is changing rapidly, with the potential for some undesirable outcomes. For example, many in Congress are concerned about the provision of uncompensated hospital care for the medically indigent. Although it has always been Medicare's tradition to pay only for Medicare patients, some of the current operating margins on PPS payments may be corss-subsidizing uncompensated care. In this case, if the Congress decides to restrain PPS payments, it may want to consider new initiatives for uncompensated care at the same time.

In this regard, it is also essential that we commend your Subcommittee's outstanding efforts last year to adopt a fool-proof disproportionate share hospital adjustment that could not be tampered with by the Administration, and to exempt the most significantly disproportionate hospitals from the repeal of the Periodic Interim Payments Program. It is imperative that these protections be preserved this year against those who would seek to cut back on them.

The Impact of Indigent Health Care on Hospitals

Written testimony by Ron J. Anderson, M.D., president & chief executive officer of Parkland Memorial Hospital in Dallas, Texas, and chairman of the Texas Board of Health. Submitted to the Subcommittee on Health of the House Ways & Means Committee, March 12, 1987.

To outside observers, the current picture of the financial condition of the nation's hospitals must be confusing, to say the least. In general, hospital utilization is down, but profits are up. Hospitals have become increasingly entrepreneurial and marketing oriented. Now, even the term "hospitals" is considered anachronistic. Instead, we speak of "health care systems." And the line between for-profit and non-profit hospitals, or systems, has become almost invisible. This is a generally accurate picture of private hospitals, but for public, tax-supported hospitals the situation is significantly different. The situation of Parkland Memorial Hospital in Dallas vividly illustrates this unsettling dichotomy.

Parkland is the public general hospital for the residents of Dallas County, which includes the City of Dallas and surrounding suburbs. Parkland is also the primary teaching hospital for The University of Texas Southwestern Medical School, which is physically connected to the hospital. Parkland currently operates about 750 beds, but by the end of this year will have a capacity of about 940 beds. It admits about 35,000 patients a year, including about 1,000 sick newborns who require intensive care.

It is officially recognized as a Level 1 trauma center, and the Parkland Regional Burn Center is one of the largest in the country. Parkland established the first special care unit in the country designed specifically for seriously injured children. This year Parkland will deliver almost 15,000 babies, making it the third largest maternity hospital in the country after Los Angeles County/USC Medical Center and Jefferson Davis Hospital in Houston, which are also public hospitals. Parkland's large outpatient clinic sees about 1,100 patients a day, or about 295,000 patients a year. The Emergency Department sees about 430 patients a day, or about 158,000 a year.

Parkland sees about one-third of the Medicaid patients in Dallas County and about one-third of the AIDS patients in the county. It receives about half of the emergency ambulance patients in the county.

In Texas, where Medicaid covers only 25 to 30 percent of the poverty level population, the large urban public hospitals make up a substantial portion of the health safety net. In fact, a study done several years ago showed that the five largest public teaching hospitals in Texas provide more uncompensated care than the entire state Medicaid program for hospital services.

Because the Texas Medicaid program covers only a small proportion of the indigent, the taxpayers of Dallas County and other urban counties finance a much larger share of the cost of public hospitals than do local taxpayers in states with more generous Medicaid programs. Parkland receives about 54 per cent of its operating revenue from Dallas County taxpayers.

This tax support is adequate to pay for the care of the poorest Dallas County residents, but since 1981, increasing numbers of uninsured, working poor who do not qualify for any assistance have caused the cost of uncompensated care to rise sharply. Since 1981, the percentage of our charges written off to contractual allowances, charity care, and bad debt, has risen from 68 percent to 73 percent. Last year, the cost of uncompensated care was about $20 million greater than the amount of tax revenue Parkland received for operations. This occurred despite an aggressive collections effort that netted a record $66 million in fiscal 1986.

In reality, the charges written off as bad debt represent care for uninsured, medically indigent patients who simply do not qualify for tax-supported care. To a large extent, these are the working poor and teenage mothers. And these are the people who have been displaced from the private sector. Legally, Parkland is no more obligated to care for these uninsured patients than are the private hospitals. Ethically, perhaps, we see things differently. Parkland has always put the patient's well-being ahead of financial considerations. In today's competitive health care environment, I am afraid the same cannot be said for many hospitals in the private sector.

That is one reason why Parkland took a strong stand on the issue of "patient dumping" and prodded the state of Texas into becoming the first state to adopt regulations that ensure patient safety and stability in transfers between hospitals. These regulations discourage transfers for

financial reasons. There is no question that health care providers have become more bottom-line conscious in recent years, but at Parkland and other public hospitals, the real bottom line is still patient care.

Strong ideals and good intentions, however, are no match for the increasing numbers of uninsured, medically indigent patients who seek care at Parkland. Since 1979, the number of patients admitted annually to Parkland has increased by 25 percent. Combined clinic and emergency room annual visits also have increased by 25 percent. The number of births has increased by 50 percent, seriously overloading existing facilities.

While private hospitals in the Dallas area have experienced occupancy rates of 70 per cent and less, Parkland's occupancy has remained in the 85 to 90 percent range. We have even approached the large private hospitals about taking some of our maternity patients for a payment well above what it costs Parkland to deliver a baby, but the private hospitals rejected the idea.

Parkland has been so full, in fact, that last year for the first time Parkland had to divert critically sick and injured patients to other hospitals because Parkland's intensive care beds were full. This is partly a result of the current nursing shortage, but it also reflects the high utilization of public hospitals.

When Parkland is so busy caring for indigent and medically indigent patients, there is literally no room to accommodate paying patients referred to our faculty physicians. Thus, we are less able to cross-subsidize uncompensated care through our paying patients. While we have about broken even on our Medicare patients, since prospective payment took effect on October 1, 1983, we have been able to do so only because of the supplements for the direct and indirect costs of medical education.

Meanwhile, the large private hospitals have sharply reduced their uncompensated care costs and have fine-tuned their staffing levels to accommodate the decreased utilization. Having financed their capital projects through private philanthropy and tax-subsidized bonds, these hospitals are able to market more lucrative services and enjoy handsome profits despite lower utilization of traditional inpatient services. This is a dramatic contrast to the plight of the public hospitals.

Public hospitals are sometimes attacked as being wasteful and inefficient, when actually they do remarkably well with the resources they have. Parkland, for example, has consistently ranked near the top in

productivity among large Texas hospitals of all types. Parkland's ratio of employes per occupied bed is below that of most large teaching hospitals.

In 1986, in order to put more emphasis on nursing care, Parkland reallocated $3 million within its budget from administrative and management categories.

Yet despite the financial pressures that Parkland has faced over the past six years, the hospital has continued to be innovative and enhance patient care and community service.

We are looking for other ways in which we can deliver health care more cost-effectively and also generate additional non-tax dollars, but we cannot expect local taxpayers to tackle the growing nationwide problem of health care for the uninsured, medically indigent.

Parkland and the other public hospitals simply will not be able to absorb all these patients who are being squeezed out of the private sector. If present trends continue, we will have no choice but to restrict care to the poorest of the poor and a few paying patients. We will have to take a hard look at services that drain our resources and discontinue them. We will not make across-the-board cutbacks, but will try to preserve a high level of quality in fewer areas.

If you, the Congress, allow this to happen, you will be forcing physicians and hospital administrators to become the executioners of an ethically corrupt social policy.

We must finally, in this country recognize that access to a defined, appropriate level of health care is a right, and not a privilege. We must begin now to take a fresh look at how we finance and provide health care and design a new system of universal health insurance. It should be a system that preserves some measure of freedom of choice, has incentives for efficiency, has built-in quality controls, and is not weighted down by excessive administrative costs.

There already is plenty of capacity and money in the system to take care of every American in need. All we have to do is find a way to give everyone a ticket. We can devise a system that is ethical, fair, and affordable. First, we must have the will to do it.

In the interim, however, we must ensure that public hospitals — the ultimate safety net for millions of Americans — do not break down under the strain of the indigent and uninsured, medically indigent. These hospitals need relief now, before irreparable damage is done. We must not wait until the lifeboat is filled to overflowing and we are shamed into action.